ALAMEDA COUNTY
PUBLIC HEALTH DEPARTMENT
OFFICE OF AIDS ADMINISTRATION
AND
OAKLAND TGA
COLLABORATIVE COMMUNITY PLANNING COUNCIL

OAKLAND, CALIFORNIA TRANSITIONAL GRANT AREA 2009 – 2011 COMPREHENSIVE HIV SERVICES PLAN

SUBMITTED TO THE
US HEALTH RESOURCES AND SERVICES ADMINISTRATION

January 2, 2009

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January 1, 2009

Douglas Morgan
Director, Division of Service Systems
HIV/AIDS Bureau, HRSA
500 Fishers lane, Room 7A-55
Rockville, MD 20857

Dear Mr. Morgan:

As Chair of the Oakland Transitional Grant Area HIV Collaborative Community Planning Council, I am pleased to assure HRSA that the Planning Council has taken a leadership role in the development and production of the Oakland TGA 2009-2011 Comprehensive HIV Services Plan.

The Council formed a Comprehensive Plan Steering Committee charged with overseeing the development of the three-year Plan. Membership was open to all Council members, representatives from core and support service providers, consumers and community members. The Steering Committee met regularly throughout the fall of 2008.

The Steering Committee reported to the Council and to its Executive Committee on Plan development and produced a variety of documents including the Plan's goals, values and guiding principles for Council input and approval.

The 2009-2011 Comprehensive Plan is intended to serve as a living document and a road map that will guide the Oakland TGA in its efforts to reduce the number of people who are out of HIV primary care, and to improve health outcomes for people living with HIV in Alameda and Contra Costa counties.

I would be pleased to answer any questions regarding the role of the Council in the development of this Plan.

Sincerely,

Roosevelt Mosby
Chair, Oakland TGA Collaborative Community Planning Council

CONTRIBUTORS AND INTRODUCTION

The 2009 - 2011 Comprehensive Plan for HIV service delivery in the Oakland Transitional Grant Area (TGA) is the product of a planning and development process spearheaded by a diverse group of consumers, providers, and HIV specialists from both Alameda and Contra Costa Counties. These individuals collaborated during the second half of 2008 to chart a course for the future of HIV services in the Oakland TGA that will allow our region to use Ryan White Care Act Part A funds efficiently in order to make the greatest possible positive impact on the HIV/AIDS epidemic in our region.

A Comprehensive Plan Steering Committee comprising Planning Council members, service providers, managers and staff from the Alameda County Office of AIDS Administration and the Contra Costa Health Services Department AIDS Program, and community members met regularly to oversee the development of the three-year Plan.

The Executive Committee of the Planning Council and the full Planning Council reviewed and approved key components of the Plan, most importantly the goals and objectives for future development and refinement of the TGA's Continuum of Care.

The following are the Oakland TGA Comprehensive Plan Steering Committee members:

- Elaine Bautista, MPH, Epidemiologist, Community Assessment Planning & Education (CAPE) Unit, Alameda County Public Health Department
- Angel Fabian, La Clinica De La Raza, Inc., and Planning Council member
- Carla Goad, MA, Education and Services Supervisor, Contra Costa Health Services Department AIDS Program, and Planning Council member
- Tezima Jenkins, Program Coordinator, Alameda County Office of AIDS Administration
- Roosevelt Mosby, Chair of the Oakland TGA Collaborative Community Planning Council, and Executive Director of the Sexual Minority Alliance of Alameda County (SMAAC)
- Tom Mosmiller, Alameda County Office of AIDS Administration, Program Manager
- Adam Ouderkirk, Director of Contracts, AIDS Healthcare Foundation (AHF)
- Deborah Royal, RN, Nurse Practitioner, East Bay AIDS Center (EBAC) and Planning Council member
- Lori Williams, Director of Care and Prevention, Alameda County Office of AIDS Administration and Planning Council member
- Bonnie Wheatley Program Administrator, Alameda County Medical Center, Highland Hospital

Staff of the Alameda County Office of AIDS led by Kabir Hypolite, Director, and Lori Williams, Director of Care and Prevention participated in the preparation of the Comprehensive Plan document through review and revision and attendance at Comprehensive Plan Steering Committee meetings.

Patricia Calloway, former Quality Management Coordinator for the Oakland TGA, provided assistance with goals and objectives related to quality management.

Management and staff of the Contra Costa County Office AIDS Program also provided support to the planning process, and helped formulate key Plan sections. Carla Goad of the Contra Costa AIDS

Program was a Steering Committee member. Christine Leivermann, MPH, Director of the Contra Costa AIDS Program, also reviewed and revised key sections of the Plan.

The following service providers also contributed to the Plan's development:

- Alvin Quamina, Executive Director, AIDS Project of the East Bay, Oakland, California
- Caitlin McCarthy, RN, Nurse Manager, Alameda County Medical Center – Adult Immunology Clinic , Oakland, California
- Lois Lindsey, Associate Director, Alameda Health Consortium, HIV Dental Program
- Franzetta Houston, Chief Operating Officer, Ark of Refuge, San Francisco, California
- Steve Obrien, MD, East Bay AIDS Center, Oakland, CA
- Nancy Halloran, MPH, Program Developer, Health Equity Partnership & Community Institute for Healthcare Equity
- Tiffany Woods, Tri Cities Health Center Transgender Services, Fremont, California,

Executive Summary

In developing this Comprehensive Plan, contributors sought to design a continuum of care that would increase access and improve health outcomes for the thousands of people in Alameda and Contra Costa Counties who live with HIV or AIDS (PLWH/A). Consumers of Ryan White services in the Oakland Transitional Grant Area (TGA) are typically poor and increasingly people of color who are marginalized due to sexual minority status, disability, race and other factors, and who in their daily lives confront a range of social inequities.

Despite the best of intentions, many contributors to this Plan wish to affirm that the goals of no disparities and a hundred percent access to services are constrained by the reality of these social inequities represented in part by the diminishing funding from all sources for the provision of medical care and other support services for low income people living with HIV.

Nonetheless, the 2009 - 2011 Oakland TGA Comprehensive HIV Services Plan is designed to serve as a working blueprint to guide the refinement of HIV/AIDS care and support services in Alameda and Contra Costa Counties over the next three years through the strategic use of limited resources.

Developed through a collaborative process involving the local Planning Council and our region's two County AIDS programs, the Plan is designed to strengthen coordination and integration of local HIV core and support services, to improve linkages between service agencies and to link care and prevention. The Plan is intended as a living document whose goals, objectives and specific tasks are to be revisited and updated as the three year period unfolds in order to respond to changing needs of our target populations, and to incorporate new strategies for improving care and increasing parity of access to services.

The progress our TGA has made in reducing the percentage of individuals who have an unmet need for HIV medical care is continually challenged by the growing complexity of newly-diagnosed hard to reach populations, and the need for care strategies that are effective in meeting the needs of multiply-diagnosed individuals, low income people, and sexual minorities.

The Plan's goals are to

1. Provide access to and retain in high quality HIV medical care those who are aware of their status but not in care.

2. Optimize the continuum of care's impact through development and assessment of a series of pilot projects intended to improve efficiency, identify and use all available resources, eliminate duplication and competition, better organize and share limited resources, strengthen data collection and make better use of technology.

3. Enroll out of care clients in medical care.

4. Insure that services are of the highest quality through implementation and monitoring of a Quality Management Plan.

S E C T I O N 1

Where Are We Now? What Is Our Current System of Care?

Description of the Oakland TGA

Located east of San Francisco, the Oakland Transitional Grant Area (TGA) is a tri-jurisdictional entity comprising the public health departments of Alameda and Contra Costa counties and the City of Berkeley in Alameda County. The City of Berkeley is its own health jurisdiction, but collaborates with both counties in TGA-wide planning for HIV treatment and prevention services.

According to the 2000 census, the total population of the Oakland TGA is 2,481,745. Fifty-nine percent of the TGA's population resides in Alameda County and forty-one percent in Contra Costa County. The City of Oakland in Alameda County is the TGA's largest city with a population of approximately 400,000.

The Oakland TGA is one of the most ethnically diverse regions in the state of California and in the nation. A quarter of Contra Costa residents and over a third of Alameda County residents speak a language other than English at home. The TGA is 51% white, 21% Hispanic/Latino, 21% Asian/Pacific Islander, 11% African American, 1% Native American/Alaskan native, and 16% multiethnic/other. Exhibits one and two illustrate the racial and ethnic diversity of the two counties.

Exhibit One

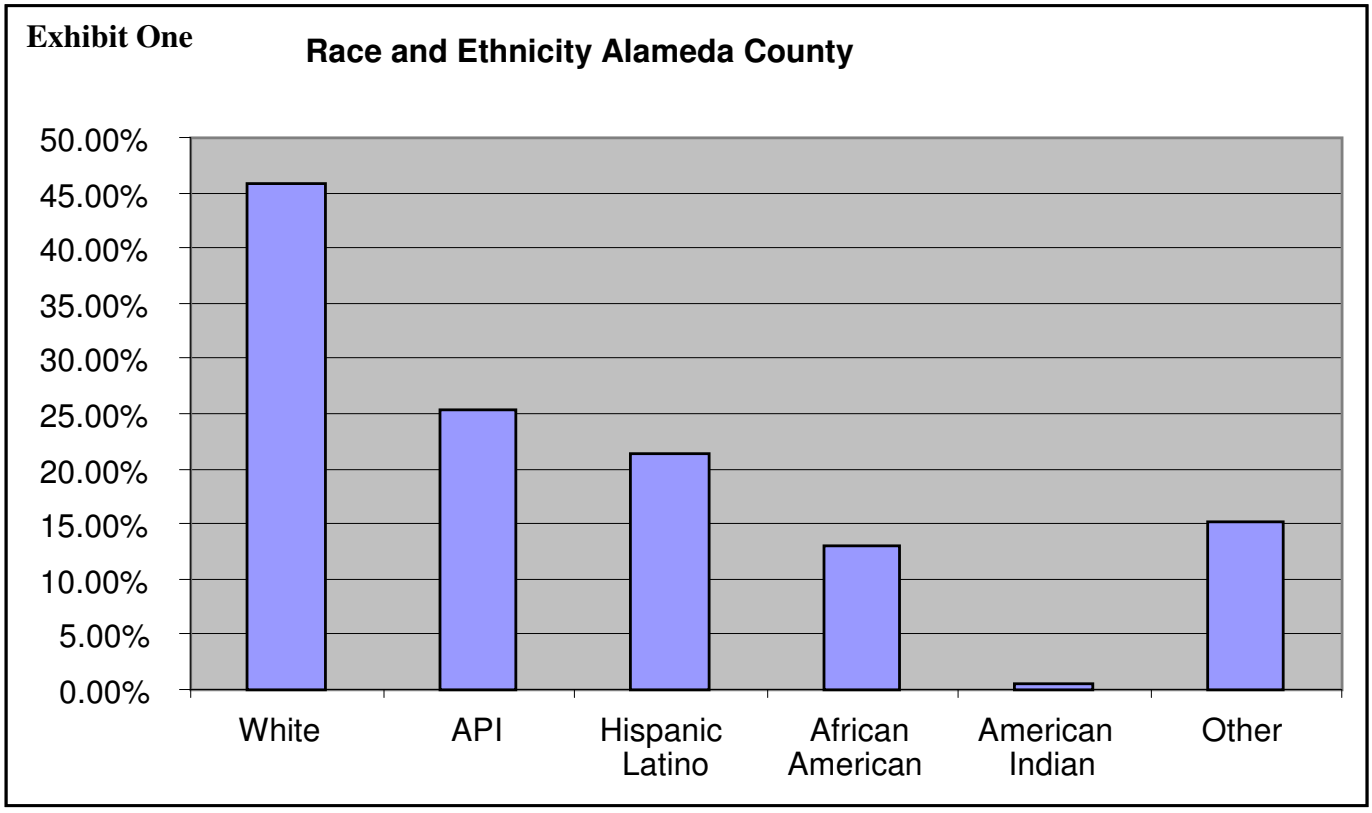
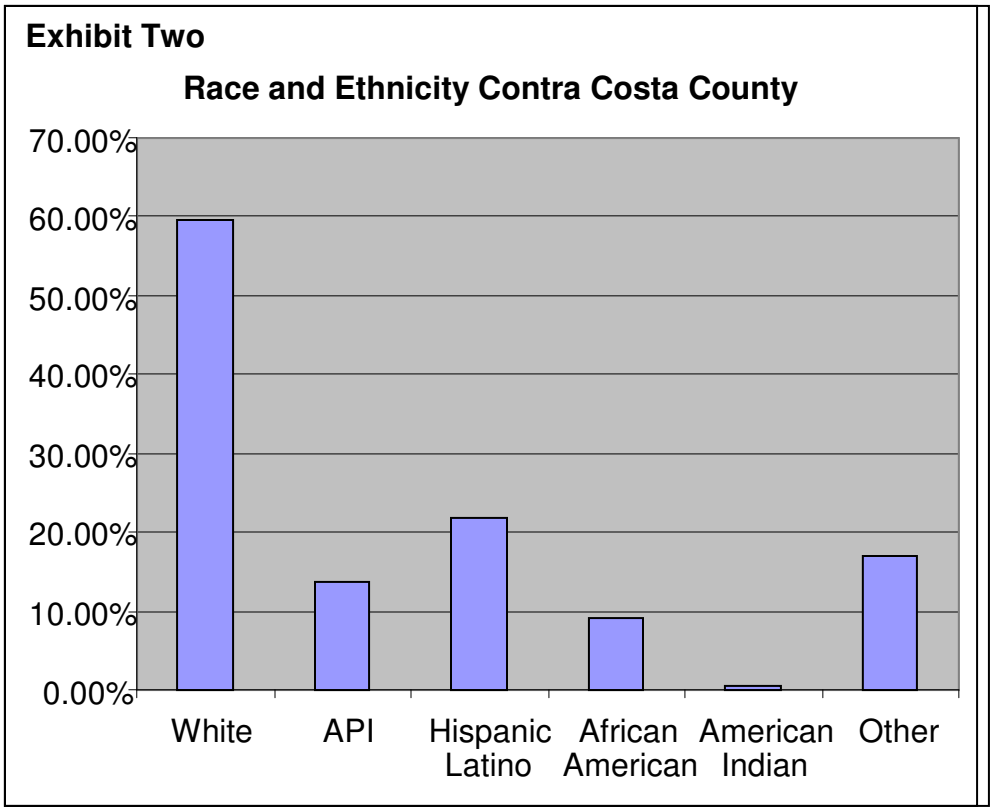


Exhibit Two



Income and Poverty

About 20% of Alameda and Contra Costa County households live below 200% of the Federal Poverty Level. In 2007, the California Budget Project estimated that the basic cost of living in the region for a family with two working parents is $77,000. The high cost of living, especially the cost of housing and transportation, creates barriers to accessing HIV care and support services for the Oakland TGA's Ryan White clients.

Epidemiological Profile

Although the downward trend in the number of new infections and AIDS diagnoses since the height of the epidemic in 1992/1993 is a welcomed development, HIV now disproportionately affects low income people of color, especially heterosexual African Americans and growing numbers of Latinos. HIV/AIDS incidence (annual new cases) and prevalence (the number of currently living cases) have become concentrated in low income, minority neighborhoods in the City of Oakland in Alameda County and the cities of Richmond, San Pablo and Pittsburg in West and East Contra Costa County. Oakland has a third of Alameda County's population but approximately half the County's AIDS cases. Richmond and San Pablo in Contra Costa have the highest cumulative incidence of AIDS in that county at six per thousand residents and five per thousand residents respectively.

Although African Americans are only 11% of the TGA's general population, they represent the greatest proportion of prevalent cases of AIDS (43%), the greatest proportion of recent AIDS incidence (50%) and the greatest proportion of recent HIV (not AIDS) prevalence (42.25%).

Men who have sex with men (MSM) still represent the highest prevalence and incidence. But the heterosexual proportion of both incidence and prevalence is growing.

This change in the populations affected by HIV/AIDS requires a flexible response on the part of local health jurisdictions especially regarding the cultural competency of clinicians, case managers and other core and support service providers.

According to local HIV/AIDS Reporting System (HARS) data, there were 6,997 PLWH/A in the TGA as of December 31, 2007. HIV (not AIDS) prevalence was 2,738; AIDS prevalence was 4,259, and AIDS incidence in the two year period January 2006 through December 31 2007 was 548.

In Contra Costa County, Whites make up just under half of both HIV (not AIDS) prevalence and AIDS prevalence, and just under a third of AIDS incidence in the 2006-2007 period. African Americans constituted approximately 30% of both HIV (not AIDS) prevalence and AIDS prevalence, and over 44% of AIDS incidence (new cases) in the same period. Hispanics were 16% of HIV (not AIDS) prevalence and AIDS prevalence, and 18.5% of AIDS incidence in the 06-07 period. Asian Pacific Islanders are 2.4% of the HIV (not AIDS) prevalence, 3.4% of AIDS prevalence and 7.7% of AIDS incidence.

In Alameda County, African Americans constitute 46% of both HIV (not AIDS) prevalence and AIDS prevalence, and were over half of AIDS incidence in the 2006-2007 period. Whites are a third of both HIV (not AIDS) prevalence and AIDS prevalence and about a quarter of AIDS incidence. Hispanics are 12.4% of HIV prevalence, 14.2% of AIDS prevalence and 15.3% of AIDS incidence in the 2006-2007 period. Asian/Pacific Islanders (API) are 4% of HIV prevalence, 4.4% of AIDS prevalence and almost 6.5% of AIDS incidence in 06-07.

Exhibit 3 AIDS Prevalence in the Oakland TGA By Race and Ethnicity (As of 12/31/2007)

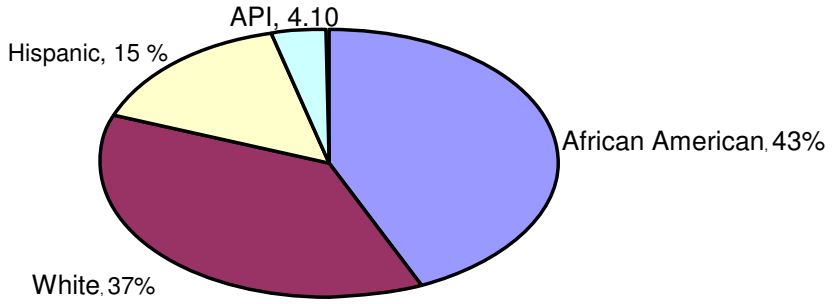
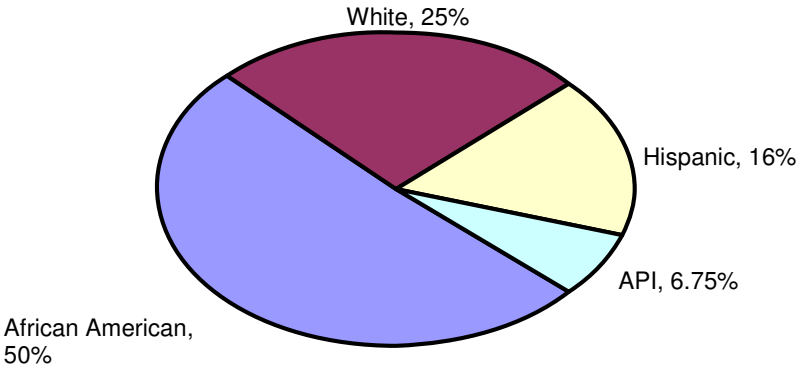


Exhibit 4 AIDS Incidence by Race and Ethnicity Oakland TGA (2006-2007)



AIDS Case Rates By Race

Exhibit 5 AIDS Rates by Race per 100,000 Residents Alameda County

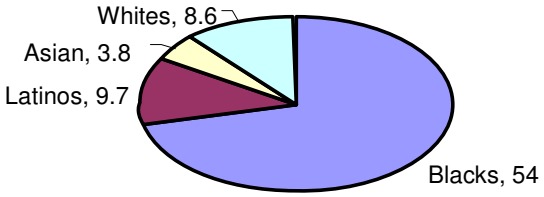
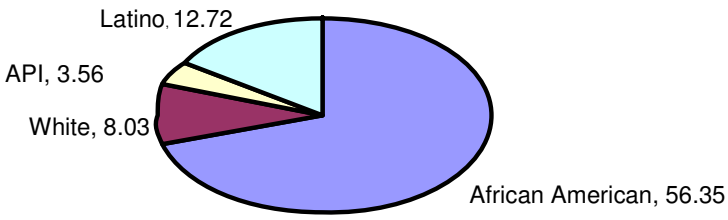


Exhibit 6 AIDS Case Rates Per 100,000 Residents Contra Costa County

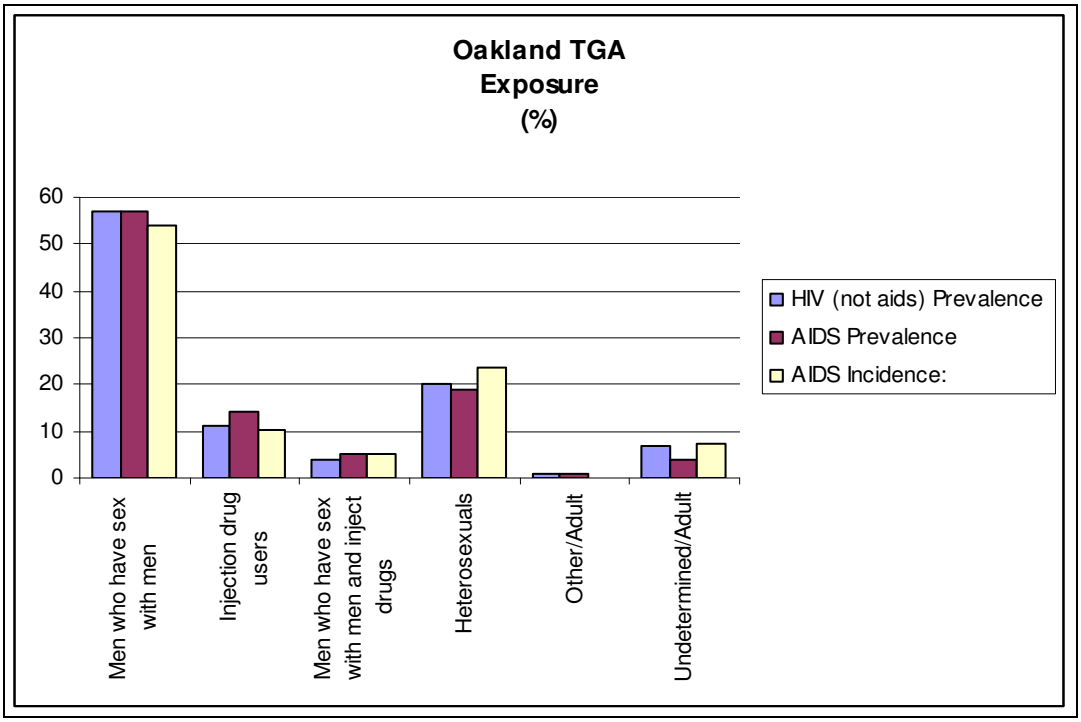


Exposure

In both counties, Men who have sex with men (MSM) is the highest exposure category. In Alameda County MSM were 56% of HIV (not AIDS) prevalence, 57% of AIDS prevalence and nearly 52% of AIDS incidence in the 2006-2007 period. In Contra Costa County, MSM were approximately 61% of HIV (not AIDS) prevalence, 56% of AIDS prevalence and nearly 59% of AIDS incidence during this period.

Exhibit 7 illustrates the distribution among exposure categories for the TGA as a whole.

Exhibit 7



Heterosexual contact is now the second highest exposure category in both counties. In Alameda County heterosexuals were about a fifth of both HIV (not AIDS) prevalence and AIDS prevalence and a quarter of AIDS incidence. In Contra Costa County, heterosexuals were about 13% of both HIV (Not AIDS) prevalence and AIDS prevalence and AIDS incidence in the two year period ending December 2007.

Injection Drug Use (IDU) is the third highest exposure category in both counties. In Alameda County IDU accounted for slightly more than 10% of both HIV (not AIDS) prevalence and AIDS prevalence and just under 10% of AIDS incidence in the calendar years 2006-2007. In Contra Costa, IDU were 13% of HIV (not AIDS) prevalence, 18% of AIDS prevalence, and 12.5% of AIDS incidence in 2006-2007.

Co-Factors

A number of factors complicate or confound HIV treatment and prevention.

Sexually Transmitted Infections (STIs)

STIs increase the risk of HIV infection and transmission and are an indicator of unprotected sexual activity, a significant behavioral risk factor in the transmission of HIV.

Gonorrhea

Gonorrhea is a sexually transmitted infection caused by the bacterium *Neisseria gonorrhoeae*. There were 155 cases per 100,000 residents in Alameda County and 92 cases per 100,000 residents in Contra Costa County in 2007. The California case rate for that period was 90 per 100,000.

In Contra Costa, 64% of female cases and 58% of male cases were among young women and men between the ages of 15 and 24. Half of both male and female cases were African American. In Alameda County 73% of female cases and 50% of male cases were among young people 15 to 24 years old. 53% of female cases and 62% of male cases in Alameda County were African American.

Chlamydia

Chlamydia, caused by the bacterium *Chlamydia trachomatis*, is one of the most common sexually transmitted infections. In 2004, 1,175 cases of Chlamydia in the low income, minority neighborhoods of West Contra Costa accounted for 43% of all infections in the county (2754) and nearly 71% of the cases were in young people under 25 years of age.[1] 73% and 57% percent of the female and male cases respectively were between the ages of 15 and 24. Over 70% of all cases were African American or Latino.

In 2007, reported cases of Chlamydia in Alameda County increased by 15% from the preceding year. Approximately 73% of female cases and 55% of the male cases were youth 15 to 24 years old. 53% of the female cases were African American and 26.7% were Latina. 62% of the male cases were African American and 18.5% were Latino.

Syphilis

Syphilis is a sexually transmitted disease caused by *Treponema pallidum*. The infection causes a genital ulcerative disease that may contribute to transmission of HIV infection. There were 73 cases of infectious syphilis (primary, secondary, and early latent syphilis) reported in 2007 in Alameda County and 40 reported in Contra Costa County. [2] 94% of Alameda's primary and secondary syphilis cases and 92% of the early latent syphilis cases were men. In Contra Costa, all of the 27 primary and secondary cases were men and 69% of the early latent cases were men.

Tuberculosis

Service data indicates 27 Ryan White clients served in the last Ryan White fiscal year were co-infected with TB and HIV.[3] Although epidemiological data revealed no new cases in persons

[1] Contra Costa Health Services Department, Sexually Transmitted Disease Program special data run. Also see data links at ccpublichealth.org

[2] California Department of Health Services STD Control Branch. "Chlamydia, Cases and Rates, California Counties & Selected City Health Jurisdictions, July 2008.

[3] Intake Summary Report March 2007 – Feb 2008; Alameda County Office of AIDS

diagnosed in Contra Costa with HIV infection, service data shows six clients were co-infected with HIV and TB.

In 2007, there were 155 cases of TB in Alameda County (excluding the city of Berkeley). This is an increase of 6% from 2006.

Mental Health and Substance Abuse

About a third of all Oakland TGA Ryan White Part A clients present with mental health problems. The most commonly reported mental health problem in the TGA's 2007 Needs Assessment was depression with 40% of Needs Assessment Consumer Survey respondents reporting being diagnosed and treated for depression within twelve months of the survey. Transgender individuals (almost all Male to Female or MTF) and women of color reported being diagnosed and treated more frequently than other groups with 66% of transgender individuals and 48% of women of color reporting diagnosis and treatment for depression.

Hepatitis C

Due to high rates of injection drug use, Hepatitis C remains a significant health concern in Contra Costa County where local estimates indicate that more than 28,000 individuals may be infected. The Alameda County Department of Behavioral Health Care Services estimates that 26,000 to 32,000 persons are infected with HCV in Alameda County.[4]

Needle exchange as one part of a comprehensive continuum of services for injection drug users is used in both counties as a Public Health measure to reduce transmission of HIV and other blood borne diseases.

Incarceration

A total of 65,000 prisoners from state prison and local jails have been released to Alameda and Contra Costa counties over the last three years. (High rates of recidivism are one of the reasons for the large number of annual releases). Local county jails in Alameda and Contra Costa County have released 41,000 of these prisoners,[5] and the California Department of Corrections has released the other 24,000. Most return to the low income neighborhoods in either Oakland in Alameda County or Richmond and San Pablo in Contra Costa.

The most recent estimate of seroprevalence in the California prisoner populations is 3%[6]. In a randomized prerelease interview conducted by a northern Californian community based organization, 10% of informants self-reported as HIV positive. Using these two estimates as a range, it is estimated that at least 2,000 individuals with HIV/AIDS have been released from prison or jail to the Oakland TGA over the last three years.

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[4] Alameda County Health Department, Division of AIDS and Communicable Disease, *Memo to Hepatitis C Task Force*, 2001.
[5] Dr. Harold Orr, Medical Director, Alameda County Jails
[6] Jessica Anne Clarke, MD, PhD; Chief Medical Officer (A) San Quentin Prison California Department of Corrections and Rehabilitation; Pacific AIDS Education and Training Center; Asilomar September 2005 and National Commission on Correctional Health Care.(2002). "The health status of soon-to-be-released inmates: A report to Congress". Chicago: National Commission on Correctional Health Care

Because the reentry population deals with a wide variety of health problems including hepatitis, serious mental illness and substance use in addition to HIV, comprehensive and coordinated services anchored in medical case management are essential to health maintenance and HIV transmission prevention.

Emerging Populations / Future Trends

Epidemiological data indicates the following future trends in the Oakland TGA:

- An increase in the number of women, especially African American women, but also other women of color among new infections.

- Increases in the numbers of infections among Latinos. Although the proportion of annual new AIDS cases among Latinos has not consistently surpassed the percentage of Latinos in the general population, there has been an upward trend over the last ten years in annual AIDS incidence among Latinos. The proportion of total cases for which Latinos accounted doubled between 1995 and 2005.

- According to the Oakland TGA's most recent Unmet Need Framework (an estimate of unmet need for primary medical care among PLWH/A) Asian/Pacific Islanders, youth, PLWH/A 45 and older and women demonstrate unmet need for primary health care in greater numbers than their proportions among PLWH/A in the TGA's HARS surveillance data, implying an ongoing need for focused prevention efforts and recruitment into primary care for these populations.

- Although youth 13-19 have consistently constituted less than 1% of the TGA's annual AIDS incidence in recent years according to local HARS data, extremely high rates of STIs among young people, especially Chlamydia among young women of color in West Contra Costa, indicate the possibility of higher rates of HIV infection than the HARS data shows in this population.

- High rates of HIV infection among the thousands of former prisoners who return each year from state prisons and local jails will continue to require outreach and HIV prevention efforts targeting this population.

- ***IDUs:*** The IDU proportion of AIDS cases and HIV infection has risen over the course of the epidemic. Chaotic lifestyles are among the many environmental influences strongly correlated with inconsistent access to and adherence with care and treatment recommendations. The drug use and relapse that are common among recovering substance users mean that their care is often interrupted and that they will continue to place additional strains on the public HIV health care system.

- ***Transgender:*** County health officials, case managers and community based organizations that work with transgender individuals in Alameda and Contra Costa Counties have begun to explore the possibility that AIDS incidence and HIV infection rates among transgender

people are underreported, and that high rates of infection and unmet need exist in this population.

Description of the History of Local, State and Regional Response to the Epidemic

The Ryan White CARE Act is intended to help communities and states increase the availability of primary health care and support, to increase access to care for underserved populations, and to improve the quality of life for those affected by the epidemic. The CARE Act directs assistance to the following areas:

- *Part A* provides funding to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) with the largest numbers of reported cases of AIDS to help meet the emergency service needs of people living with HIV. At least 75% of the grant funds must be spent on core medical services, such as primary care, dental, home health care, mental health, substance abuse treatment and medical case management services.

- *Part B* provides funding to States for HIV/AIDS services including services such as AIDS Drug Assistance Program (ADAP) and Emerging Communities (ECs) grants.

The Alameda County Public Health Department's Office of AIDS Administration (OAA) is the Oakland TGA Grantee for CARE ACT Parts A and B. The OAA funds approximately twenty agencies that provide services in Alameda County. The OAA also works closely with providers funded through the Ryan White Program Parts C and Part D.

Contra Costa County Contra Costa Public Health Department AIDS Program uses a portion of the TGA's Part A funds under the guidance of the Contra Costa HIV/AIDS Consortium. In a 2000 site visit, the HRSA fiscal consultant reviewing Contra Costa's system of care indicated that Ryan White CARE Act funds could not be used to supplant funding of services provided by Alameda County Behavioral Health Care (BHC). Because of this directive, Contra Costa allocates only a small amount of funding to primary care.

- *Part C* provides funding for HIV/AIDS Early Intervention Services (EIS) and Capacity Development and Planning Grants. The Alameda Health Consortium is the Part C grantee in Alameda County and uses Part C to fund HIV ACCESS, a coordinated system of early intervention services and comprehensive care for PLWH/A in Alameda County. Contra Costa Health Services is the grantee for Part C projects in Contra Costa. In Contra Costa, Part C funds HIV Early Intervention Service targeting the County's poorest neighborhoods.

- *Part D* provides funding to public and private organizations for family-centered HIV/AIDS services for women and children. Children's Hospital and Research Center - Oakland is the Oakland TGA grantee for Part D, which funds the Family Care Network, a consortium of agencies in the East Bay of the San Francisco Bay Area that provides comprehensive, family-centered services across disciplines to women, children, youth and families living with HIV.

The Alameda County Housing and Community Development (HCD) Department administers the Housing Opportunities for Persons with AIDS (HOPWA) program. HOPWA supports housing development and provides housing support and related services for PLWH/A.

The Alameda County Public Health Department, Division of Communicable Disease Control and Prevention (DCDCP) and the Community Assessment Planning and Education Unit (CAPE) produce an annual AIDS Epidemiology Report for Alameda County. In Contra Costa the Health Services Department's Public Health Division, Communicable Disease Program produces that County's AIDS Epidemiology report.

- *Part F* provides funding to AIDS Education and Training Centers (AETCs), the Minority AIDS Initiative (MAI) and Special Programs of National Significance (SPNS).

The Oakland EMA HIV Health Services Planning Council was created in 1994, soon after Alameda and Contra Costa Counties became eligible for Care Act funding, to oversee regional planning for the entire EMA (now TGA).

The Contra Costa HIV/AIDS Consortium, an umbrella network of clients, providers and interested community members was created in 1992 to address the issue of HIV and AIDS in Contra Costa County. Since 1994 the Consortium has overseen local plans and processes for programs funded through HRSA Care Act Part A and B (Formerly Titles 1 and 2).

Local State of Emergency

In 1998 Alameda County became the first municipality in the nation to declare a state of emergency due to the disproportionate number of AIDS cases occurring in the black community. The County's Board of Supervisors approved the declaration unanimously. The declaration was crafted by a multi-agency coalition of public and private health and welfare agencies and community leaders.

Merger of Prevention and Care Planning Councils

Beginning in late 2004 Alameda County began the process of merging the HIV service and prevention planning councils into a single body whose members would work together to address HIV care and prevention needs in a coordinated manner, and to develop strategies for integrating HIV care and prevention.

The first joint meeting of the newly merged Oakland TGA Collaborative Community Planning Council was held in February 2005.

The Council membership includes a representative from Contra Costa County as well as HIV prevention and treatment service consumers.

Assessment of Need

The Alameda Office of AIDS administration contracted with the Human Investment Research Center (HIRE) at California State University East Bay to develop and conduct a Needs

Assessment, including a client survey, for the Oakland TGA. The Center completed the assessment and submitted its report in the summer of 2007.

Profile of Client Survey Respondents

- Over half of the respondents were between 25 and 45 years old, 10.7 % were under 25 years old, and 33.6% were 46 years old or above.
- 57% were male, 34% female, and 8.7% were male to female transgender.
- 64.5% of respondents were African American, 20% Latino, 7% mixed race, 5.7% were White and 1.4% were Asian/Pacific Islander.
- Most respondents were heterosexual (43.6%). MSM constituted 37% of respondents; bisexuals were 15.7% and Lesbians were 2.1%.
- 22% of respondents spoke Spanish.
- 70% of respondents had a high school education or less
- 80% earned less than $11,600 a year.

Sixteen percent of respondents indicated that they had a simultaneous positive HIV test and AIDS diagnosis.

Most respondents indicated that they saw a doctor less than 12 months after their first HIV positive test result. 17% had waited from one to four years before seeing a doctor for the first time since test results; 3.5% had waited for 5 years or more, and about 10% did not remember how long they waited before seeking medical care.

For those that delayed care or sought care sporadically, almost all said that getting sicker was what prompted them to return to medical care. About 20% of respondents had not gone to see a doctor or visited a clinic for a period of more than 12 months since they tested positive. About 24% had waited for at least one period of more than six months, and about 7% for at least one period of more than a year.

Exposure and Risk

Sixty percent believed they were exposed through sex with a man, 6.5% through sharing needles, and 10% through sex with a woman. 47% of respondents described sexual partnering with multiple partners or in open relationships. 20% of respondents described their sexual behavior as high risk for transmission of HIV to their sexual partner, 18% as no risk of transmission, 29% as low risk, and 17% as moderate risk. 15% reported not being sexually active.

Substance Use

A substantial percentage of respondents reported substance use, with alcohol being the most common (60%) followed by marijuana/hashish (45%), and crack/cocaine (21%). Other respondents used heroin, other injectable drugs, and methamphetamines.

Estimated level of service gaps

Respondents were asked to indicate which core services they needed, whether they received the service, and the degree of satisfaction they experienced with each service.

The top five core medical services respondents indicated they needed were dental care, case management, medical care, assistance paying for medical insurance premiums, and ADAP treatments.

Primary Medical Care

80% of respondents reported being satisfied with the level of primary care services they received.

Medical Case Management

Medical case management is an especially important service category for the Oakland TGA's client population because many clients have difficulty keeping appointments and taking medications as prescribed.

Although the Needs Assessment found a surplus of medical case management services, 23% of survey respondents reported intervals longer than six months without medical care, and 20% reported going for more than a year without care. These findings indicate a need for stronger medical case management and closer coordination and collaboration among providers of all services.

Oral Health

The Needs Assessment indicated a nine percentage point gap between the amount of dental care needed and care received. Clients reported long waiting times for appointments. Some respondents indicated that they were not aware that they were eligible for dental services.

Mental Health Therapy and Counseling

The Needs Assessment found no significant gap in availability of mental health services. Sixty-three percent of survey respondents indicated that they were satisfied with the mental health services that they had received.

Home Health Care

The Needs Assessment found a 10% point gap between the amount of service needed and the amount of service received for skilled health services at home based on a written plan of care. The gap was especially high for Latinos at 25% points.

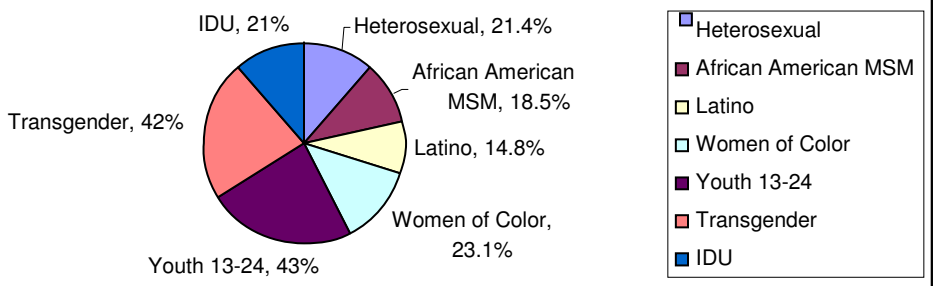
Substance Abuse Treatment

Although the Needs Assessment did not find a gap in this service category, it is apparent from the TGA-wide utilization data that completion of substance abuse treatment programs is as problematic for Ryan White clients as it is for other substance using populations: Only 7% of 249 individuals were found to have completed treatment and only 6% reported a reduction in drug use. Failure to achieve these goals does not necessarily reflect limited access or a gap in service, but may be an indication of the difficulty of achieving successful substance abuse treatment results generally.

Health Literacy

Nearly 20% of the surveyed population was unable to provide viral load information. This is of significant concern and represents an opportunity and a planning challenge to improve health status among PLWH/A. Modern treatment depends on viral load knowledge on the part of both clients and providers. Even though providers may know load levels that clients do not recall, client adherence and monitoring is based on knowledge of current and past viral load profiles. Not surprisingly, of the groups designated as special populations by the Planning Council, youth were the most likely not to know their viral load as shown in the chart below.

Exhibit 8 **Don't Know Viral Load**



Unmet Need Estimate

The California Department of Health Services (DHS) and each of California's Part A EMAs and TGAs collaborate annually to estimate the number of PLWH/A residing in each of the state's health jurisdictions who are not receiving primary medical care. California's local health jurisdictions based their approach to estimating unmet need on the "Unmet Need Framework" developed by the University of California, San Francisco.

For the most recent Unmet Need Framework, an individual with unmet need was defined as someone who was living with HIV or AIDS in FY 2006-2007, was aware of his or her positive status, and who showed no evidence of receiving HIV primary care (receipt of viral load, CD4 count, or anti-retroviral therapy) during the time period of 2006 –2007.

The unmet need estimate differs from the HARS surveillance data because it includes data from other sources as explained below.

The Oakland TGA's unmet need calculation revealed that during the period in question:

- 9,756 people were living with HIV/AIDS (PLWH/A) in the Oakland TGA jurisdiction.
- 4,665 (47.8%) were persons living with AIDS (PLWA)
- 5,091 (52.2%) were persons living with HIV (PLWH).
- 2,719 (51.5%) of PLWA and 2,558 (48.5%) of PLWH received HIV primary medical care

- 1,946 (43.4%) of PLWA and 2,533 (56.6%) of PLWH demonstrated an unmet need for HIV primary medical care.

Methods:

Unmet need for medical care among PLWH/A was estimated as follows:

DHS matched HIV and AIDS cases from the HIV/AIDS Reporting System (HARS) with electronic data from the California AIDS Drug Assistance Program (ADAP), Medi-Cal claims records, DHS HIV/AIDS client management system, and Kaiser Permanente – Northern California Medical Group. The datasets were merged, unduplicated and each case examined for evidence of primary care. If evidence of primary care was found for a given case in any of the databases, the case was considered "in care" and the individual's need "met". If no evidence of HIV primary care was found, the person was considered "out of care" and need "unmet".

DHS distributed data subsets to each EMA and TGA containing (a) living cases diagnosed with HIV/AIDS and reported within each EMA or TGA, and (b) cases identified as residing in an EMA or TGA at the time of receipt of ADAP, Medi-Cal, ARIES or Kaiser services. Datasets included client level information allowing the LHJs to link the cases back to programs where they had obtained services. Alameda County and Contra Costa County jurisdictions matched the data for the Oakland TGA against local HARS surveillance and laboratory data to further identify individuals "in care" or "out of care" and to determine the demographic characteristics of both in and out of care populations.

The subset was matched to locally reported lab data and cases were updated. The updated subsets from Contra Costa and Alameda counties were merged.

Caveats and Limitations

1. DHS's initial assignment of cases to TGA/EMA subsets were based on county of residence from the five databases (HARS, ADAP, ARIES, Medi-Cal and Kaiser). County of residence identified from ADAP, Medi-Cal and Kaiser were not necessarily the same as the counties of HIV or AIDS diagnosis. Subsets received from the state DHS, therefore, include cases diagnosed in the Oakland TGA, as well as out of jurisdiction cases who have recently moved to or sought care within this TGA.
2. Client level Ryan White Part A service utilization data is not readily available in Alameda County. The client level data that is available could not be matched due to an inability to replicate the unique code on which the datasets were matched.
3. The Oakland TGA is limited in its ability to obtain information on individuals in private care. Only information on Kaiser – Northern CA patients is available. This limited ability to match to private care records may overestimate the number of individuals who are out of care.
4. Age of the cases reviewed for the unmet need estimate was calculated as age at Jan 1, 2007, the midpoint of the 12 month period. This differs from the surveillance data where the age at time of diagnosis is recorded; therefore it is difficult to make age comparisons.

Findings

The PLWA and PLWH (non-AIDS) with unmet need are:

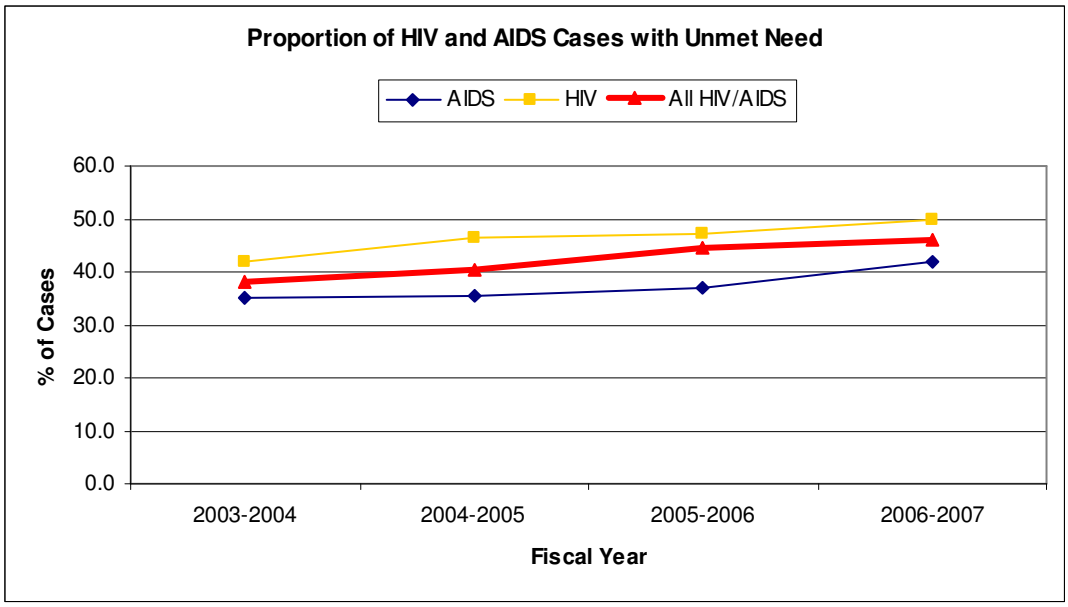
- Predominantly male (65.6%),
- Over 45 years of age (54.3%),
- Primarily African American (41.7%) or White (31.9%).
- PLWH (49.8%) are more likely than PLWA (41.7%) to have unmet need.
- Women are a larger percent of out of care (31.4%) than in care (24.0%),
- Among female HIV (non-AIDS) cases, 43% of women are out of care.
- African Americans are the greatest racial/ethnic proportion (41.7%) among individuals with unmet need.

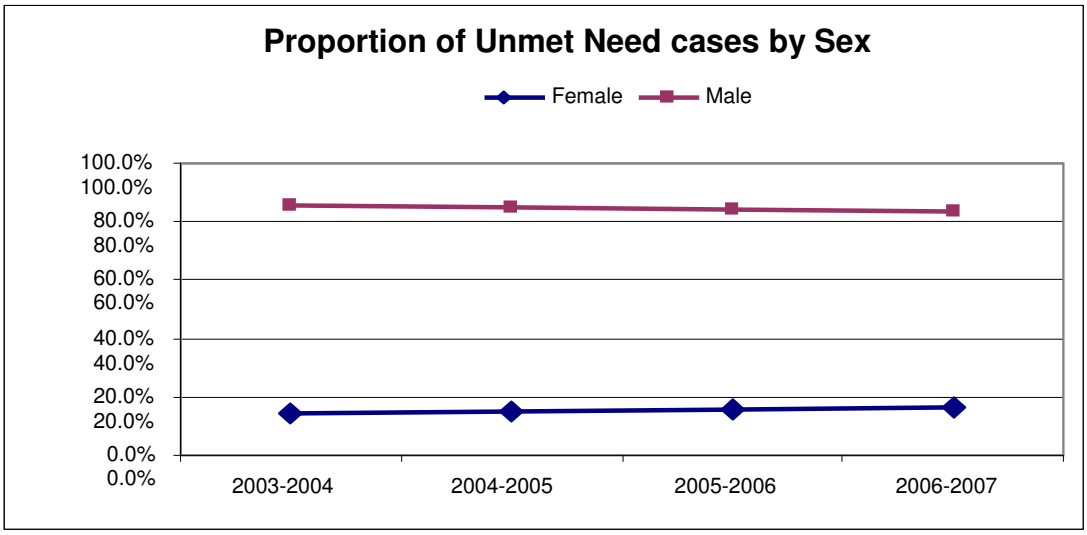
The figures highlighted in bold italics in the table below indicate populations at greater risk for being out of care than their percentage within the general surveillance population.

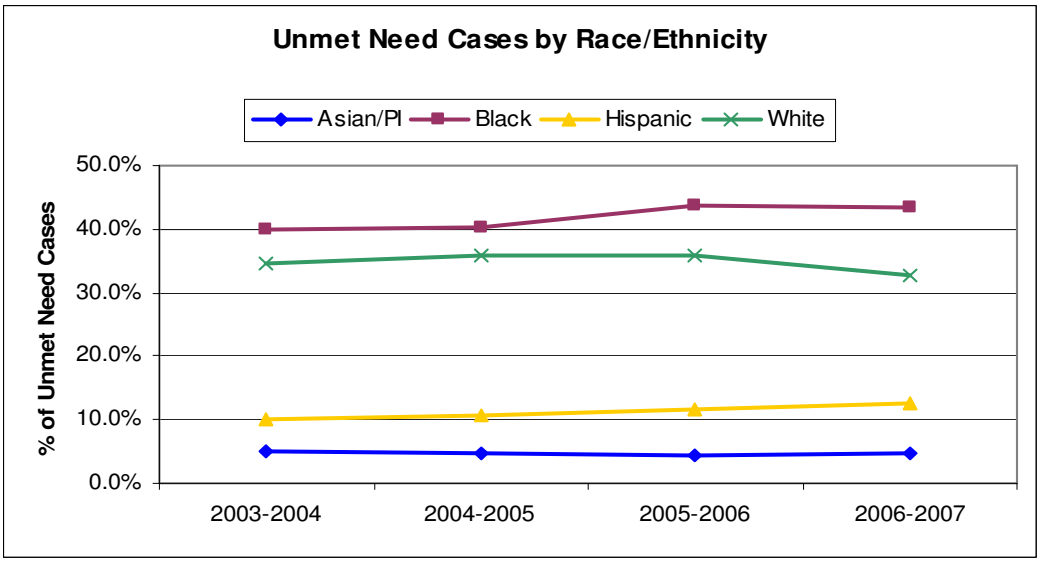
Table 1 Characteristics of HIV and AIDS Cases In- and Out of Care and PLWA/H in the Oakland TGA

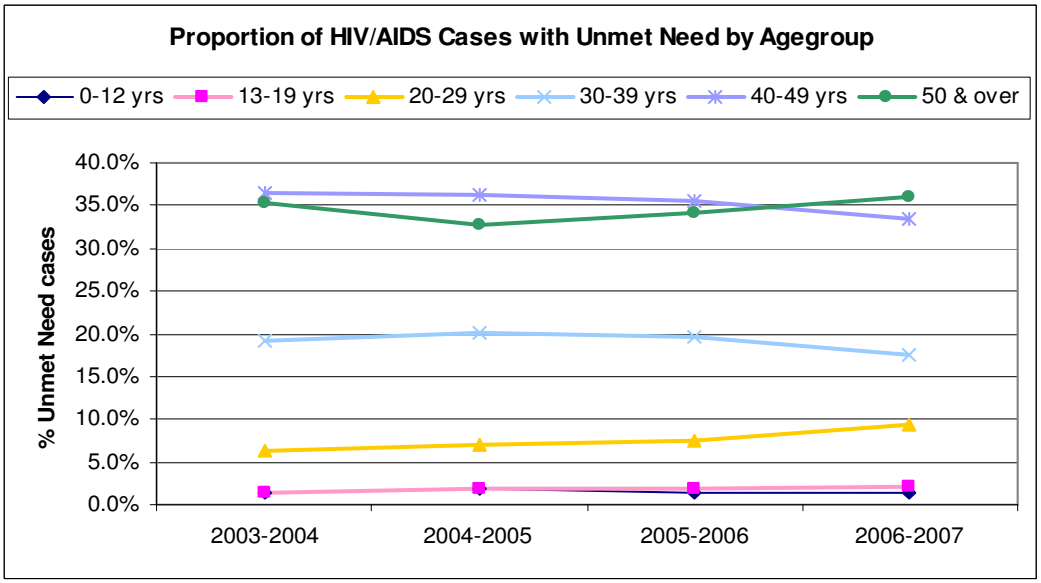
	Out of Care			In Care			Local Surveillance		
	AIDS	HIV (nonAIDS)	Total	AIDS	HIV (nonAIDS)	Total	PLWA	PLWH	Total
Total	**1946**	**2533**	**4479**	**2719**	**2558**	**5277**	**4259**	**2738**	
Gender									
Female	16.4%	***42.9%***	31.4%	18.9%	24.0%	21.4%	18.5%	21.0%	19.5%
Male	83.4%	57.1%	65.6%	81.1%	76.0%	78.6%	815%	79.0%	80.5%
Age Group									
0-12 yrs	<1.0%	***2.7%***	***1.6%***	<1.0%	1.3%	<1.0%	<1.0%	1.7%	0.9%
13-19 yrs	<1.0%	***3.6%***	***2.2%***	<1.0%	1.1%	<1.0%	<1.0%	2.0%	1.2%
20-44 yrs	32.0%	49.4%	42.0%	36.5%	49.2%	42.6%	71.6%	75.7%	73.2%
45 & over	***67.6%***	***44.3%***	***54.3%***	63.0%	48.3%	55.9%	27.1%	20.6%	24.6%
Race/Ethnicity									
Asian/PI	3.5%	***5.5%***	4.7%	4.0%	4.7%	4.3%	3.5%	3.7%	4.0%
Black	43.2%	40.5%	41.7%	40.9%	41.1%	41.0%	43.1%	42.3%	42.8%
Hispanic	12.5%	12.0%	12.2%	16.0%	13.3%	14.7%	14.6%	13.4%	14.1%
NativeAm/Alaskan	<1.0%	<1.0%	<1.0%	<1.0%	<1.0%	<1.0%	<1.0%	<1.0%	<1.0%
White	39.8%	25.8%	31.9%	38.3%	33.4%	36.0%	37.5%	37.6%	37.5%
Multi/Other//Unk	<1.0%	***6.7%***	4.0%	<1.0%	7.1%	3.7%	<1.0%	2.6%	1.3%

The following charts derived from the Unmet Need estimation process illustrate the increasing proportion of women, people of color and older people with unmet need.









Gaps in Care

Needs Assessment survey respondents were asked to indicate whether they needed and received each of the HRSA core services and support services. Their responses indicated gaps in care in the core services listed in table two.

Table 2 Gaps in Core Services	**Services Needed**	**Services Received**	**Gap**
	Percent	*Percent*	*Difference*
Assistance paying for medical insurance premiums,	34.8	20.6	-14.2

Table 2 Gaps in Core Services	Services Needed	Services Received	Gap
co-payments, and deductible			
Skilled health services at home based on a written plan of care	26.2	15.6	-10.6
Home health care services by licensed health care worker	27.0	17.7	-9.3
Dental care	47.5	38.3	-9.2
Nutrition services provided by a licensed registered dietitian	30.5	24.1	-6.4
Hospice care	16.3	12.8	-3.5
Mental health care	29.8	28.4	-1.4

Table three displays gaps in support services. The service gap in housing related services reflects in part the high cost of housing in the San Francisco Bay Area. Our Ryan White clients have particular difficulty maintaining housing stability because safe, low cost housing in Alameda and Contra Costa counties is limited.

The Needs Assessment found the largest unmet support service need in the food category with a 10% point difference between need and services received for prepared and delivered meals. Intravenous drug users often have difficulty prioritizing nutrition and frequently rely on the TGA-supported food services for basic nutrition.

Table 3 Support Service Gaps	Services Needed	Services Received	Gap
	Percent	*Percent*	*Difference*
Prepared meals	34.0	23.4	-10.0
Childcare	22.0	12.1	-9.9
Placement and care of minor children are parents are deceased are unable to care for them	23.4	14.2	-9.2
Emergency hotel vouchers	27.0	19.1	-7.9
Emergency financial assistance with rent	44.0	36.9	-7.1
Respite for care providers	17.0	11.3	-5.7
Emergency rent assistance	33.3	27.7	-5.6
Emergency financial assistance with utilities	48.9	43.3	-5.6
Interpretation and translation services	18.4	12.8	-4.2
Legal Assistance	26.2	22.0	-4.2
Assistance finding housing/ transitional housing	35.5	31.9	-3.6
Complementary care	31.2	29.8	-1.4
Emergency groceries	53.2	52.5	-.7
Peer or client advocacy	31.9	31.2	-.7

Service Gaps Among Special Populations

African American MSM

For African American MSM the most frequently noted service gaps were dental care, home health care, and assistance paying for insurance premiums and co-payments. Support service gaps occurred in childcare, physical and occupational therapy, and respite for care givers.

Latinos

For Latino respondents, significant gaps occurred in assistance paying for medical insurance premiums and home health care. In the support service category, very large gaps occurred in food, housing assistance, transportation and assistance with utilities.

Women of Color

Women of Color indicated service gaps in assistance paying for medical insurance, nutrition services, and home health care. They also indicated support service gaps in emergency housing assistance, childcare and respite for care providers.

Youth

Home health care was the largest core service gap followed by gaps in assistance paying for medical insurance and nutrition services. Youth indicated serious gaps in all housing related services.

Transgender

Transgender respondents indicated gaps in home health care, housing related services, transportation, complementary care, childcare, and assistance paying for medical insurance.

IDU

Injection drug users indicated gaps in assistance paying for medical insurance, access to clinical trials, home health care and nutrition services. Among support services, this population indicated gaps in assistance with utilities, rent and other housing costs, respite for care givers and transportation.

Prevention Needs

HIRE also conducted an HIV prevention needs assessment as part of an update of Alameda County's HIV/AIDS Comprehensive Prevention Plan. A consumer survey was conducted with a diverse sample of Alameda County residents 18 years of age and older including both HIV positive and negative individuals. The survey was conducted in the summer of 2007.

The following summarizes the survey results:

- Nearly 90% of respondents indicated that they had been tested.
- The main reasons for not testing were fear of a positive result and dislike of needles.
- 62% knew their HIV status.

- Most respondents wanted more information about the different kinds of HIV tests available, and information on where to go to get tested.
- 46% were "concerned" or "very concerned" about what people would think if they knew the respondent had been tested for HIV.

Respondents reported unmet need for a variety of prevention services including: Partner Notification, Needle Exchange, Group Education and Internet information.

Description of the Current Continuum of Care

The paramount goal of the Oakland TGA Continuum of Care is to ensure that all people living with HIV or AIDS are enrolled in primary medical care and that clients have access to primary medical care services on a regular basis.

Case Management and Primary Care are the heart of the Oakland TGA Continuum of Care. The Continuum consists of core and support service providers located throughout the TGA, although most are located in the urban centers where our clientele are concentrated: the cities of Oakland in northern Alameda County and Hayward in southern Alameda County, and in all three regions in Contra Costa (East, West and Central) in the cities of Pittsburg, Richmond, and Concord/Martinez). The geographic distribution of service providers is intended to enable clients reasonably easy access to support services, hospitals and community clinics.

Case Management

The Oakland TGA strives to make medical case management a client-centered service that engage clients in the management of their own health and well being through assessment, service planning, linkage to appropriate levels of health and support services, and through the development, monitoring and regular assessment of care plans.

In Contra Costa County, an HIV Intake Coordinator serves as a centralized source of information for providers and PLWH/A in the County, referring clients countywide to medical case management services at CBOs or the Contra Costa AIDS Program.

Support and Access Services

Support and access services help PLWH/A access and stay in care and manage HIV disease. Programs include housing related services, food and nutrition, legal services, transportation and emergency financial assistance. HIV testing programs are used to channel HIV positive clients into care as well as link to Partner, Counseling and Referral Services (PCRS). HIV testing sites are often located in community health or STD clinics community sites where high risk clients are located (shelters, public sex environments, etc), and drug treatment programs.

The Care Continuum in Alameda County

Alameda County relies on a system of public and private hospitals, community health clinics and private physicians linked through Ryan White Parts A, B, C and D funding and provider networks. Each year, the County funds more than 20 agencies to provide medical care and support services through Ryan White Care Act Parts A and B.

Most Ryan White clients in Alameda County enter the continuum through ambulatory care provided at the County Medical Center's Highland and Fairmont Campuses. Clients also enter care through Emergency Room visits at Highland Hospital, or the AIDS Health Care Foundation, as well as via primary care referrals made when an individual requests Emergency Financial Assistance at one of the Continuum of Care's support service providers. Clients may also enter through HIV counseling and testing sites, hotline referrals, and through substance abuse and mental health treatment programs. All service providers, regardless of the specific service, are contractually obligated to maintain a referral service to link their clients to primary care.

The Continuum of Care in Contra Costa County

In Contra Costa County, the Basic Health Care system (BHC) provides universal access to health care for individuals at or below 300% of federal poverty levels. BHC provides a health care safety net for individuals who do not have other resources (private or public), ensuring access to ambulatory outpatient medical care, inpatient care, lab work, x-rays and other medical procedures, medications, emergency dental care, nutrition consultations, and specialist care. All applicants must submit an application for State Medi-Cal Assistance, demonstrate proof of residency in Contra Costa, and may receive services only through Contra Costa Regional Medical Center and its referral partners.

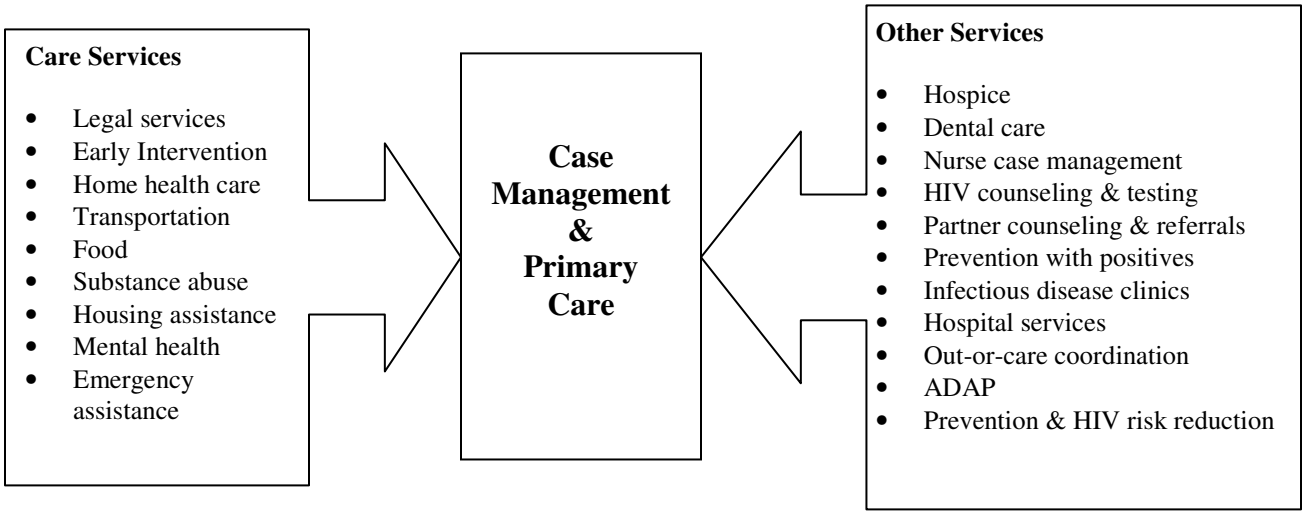
BHC provides multiple points of entry into care for HIV positive individuals by serving clients at the Contra Costa Regional Medical Center (CCRMC) and at 13 clinics throughout the county. Infectious disease / HIV specialty clinics operate in three regions and augment Contra Costa's Regional Medical Center's Family Practice healthcare model. Social workers staff the family practice and infectious disease clinics, and HIV specialists provide ambulatory care services.

- In a 2000 site visit, the Health Resources and Services Administration (HRSA) fiscal consultant reviewing Contra Costa's system of care indicated that Ryan White CARE Act funds could not be used to supplant funding of services provided by BHC.

- Because of this directive, Contra Costa allocates only a small amount of Ryan White funding to primary care as a safety net for individuals who do not qualify for BHC due to their failure to complete the BHC registration process. The small amount of Care Act primary care funding allows Contra Costa to expedite medical appointments pending completion of the BHC enrollment process.

Exhibit 9 Continuum of Care

The diagram seen in Exhibit 9 is a representation of the proposed Continuum of Care.



Resource Inventory

Agency	Services	Target Population
Ambulatory Medical Care		
Axis Community Health 3311 Pacific Ave Livermore, CA 94550 925.462.5544	Primary care, family planning, health education, HIV testing, sexually transmitted disease screening	Low income Alameda County residents including PLWH/A
Alameda County Medical Center HIV Services – Fairmont Campus 15400 Foothill Blvd San Leandro, CA 94578 510.895.4353	Comprehensive inpatient and outpatient HIV/AIDS services	Low income Alameda County residents including PLWH/A
Alameda County Medical Center Adult Immunology Clinic – Highland Campus 1411 E. 31st Street Oakland, CA 94602 510.437.4800	Acute inpatient and outpatient care, drug trials,	Medically indigent adults
AIDS Healthcare Foundation 4130 Street, Suite 200 Oakland, CA 94609	Primary care, access to specialists, psychiatric services	PLWH/A regardless of ability to pay
AIDS Project of the East Bay 1320 Webster Street Oakland, CA 94612	Acute Care; Physical Examinations, Assessments, Immunizations, Lab, Mental Health Counseling; Nursing Case Management; Health Education.	PLWH/A
Alta Bates Summit Medical Center 2450 Ashby Ave Berkeley, CA 94705 510.204.8400	AIDS Outpatient services; Health education	PLWH/A typically low income

Agency	Services	Target Population
350 Hawthorne Ave Oakland, CA 94609		
Asian Health Services 818 Webster Street Oakland, CA 94607 510.986.6830	Asian Health Services AIDS Project	Alameda County Asian Pacific Islander Community
Asian and Pacific Islander Wellness Center 358 Frank Ogaway Plaza Suite 603 Oakland, CA 94612 510.625.1578	Health education, testing and counseling	Alameda County API Community
Children's Hospital Pediatric HIV/AIDS Program 747 52nd Street Oakland	HIV testing, evaluation, treatment	Birth to 21
East Bay AIDS Center 3100 Summit Street Oakland, CA 94609 510.869.8400	Comprehensive primary HIV health care	HIV positive 13 years and older in Alameda and Contra Costa counties
HIV Education and Prevention Project of Alameda County Wellness Clinic 5323 Foothill Blvd. Oakland, CA 94601	Primary care	PLWH/A and Hepatitis C primarily Oakland residents.
La Clinica de la Raza 1515 Fruitvale Ave. Oakland, CA 94601 510.535.4000 Laclinica.org	Comprehensive health services and dental services, HIV testing,	Latino community
Lifelong Medical Care Berkeley, CA 510.20.4666	Primary medical care including HIV services and mental health services	Alameda and Contra Costa community residents
Native American Health Center	Primary health care, general dentistry,	Native Americans in Alameda County

Agency	Services	Target Population
3124 International Blvd Oakland, CA 94601 www.nativehealth.org 510.35.4400	HIV counseling and testing	
Tri City Health Center HIV / Hepatitis Services 39184 State Street Fremont, CA 94538	Adult primary care	PLWH/A in southern Alameda County
ADAP		
Alameda County Medical Center HIV Services – Fairmont Campus 15400 Foothill Blvd San Leandro, CA 94578 510.895.4353	Drug assistance	Alameda County residents with income less than $50,000
Asian Health Services 818 Webster Street Oakland, CA 94607 510.986.6830	Drug assistance	Income less than $50,000
East Bay AIDS Center 3100 Summit Street Oakland, CA 94609 510.869.8400	Drug assistance	HIV positive 13 years and older
Case Management		
Alameda County Medical Center HIV Services – Fairmont Campus 15400 Foothill Blvd San Leandro, CA 94578 510.895.4353	Coordinates home health care, hospice care, patient advocacy	PLWH/A below $50,000 annual income
AIDS Project of the East Bay 1320 Webster Street Oakland, CA 94612		

Agency	Services	Target Population
Ark of Refuge, Inc. 8715 International Blvd Oakland, CA 94621 9702 International Blvd Oakland, CA 94603 510.635.8422	Case management services	PLWH/A adults over 24 regardless of ability to pay
Asian and Pacific Islander Wellness Center 358 Frank Ogaway Plaza Suite 603 Oakland, CA 94612 510.625.1578	Case management, peer advocacy, treatment advocacy	Alameda County API Community
Bay Area Consortium for Quality Health CARE AIDS Minority health Initiative 5709 Market Street., Oakland. CA 94608 510.652.3300	Medical case management	PLWH/A regardless of ability to pay
City of Berkeley HIV/AIDS Programs 830 University Ave Berkeley, CA 94710	Medical case management, HIV testing and counseling	Berkeley residents
Tri City Health Center HIV / Hepatitis Services 39184 State Street Fremont, CA 94538	Medical case Management services	PLWH/A in southern Alameda County
Sexual Minority Alliance of Alameda County 1608 Webster Street Oakland, CA 94612 10.834.9578	Prevention Case Management	LGBTQ Youth of color
Vital life services	Medical Case Management	PLWH/A

Agency	Services	Target Population
5873 San Pablo Ave Oakland, CA 94608 510.655.3435		
Volunteers of America Bay Area HIV Services 427 7th Street Oakland, CA 94607	Prevention Case Management	Residents of Alameda and Contra Costa Counties and other Bay Area counties.
Dental Care		
Alameda County Medical Center Dental Clinic 1411 E. 31st Street Oakland, CA 94602 510.437.4473	General dentistry, oral surgery, emergency dental	Low income/ Medically indigent
Alameda Health Consortium HIV Dental Care Program 1320 Harbor Bay Parkway Suite 250 Alameda, CA 94502 510.769.2230	Free or low cost dental care	Low income PLWH/A
Mental Health		
Howie Harp Multi Service Center 580 18th Street Oakland, CA 94612 510.465.2904	Professional and peer counseling, harm reduction services, independent living skills; HIV/AIDS education support services, HIV testing	Mentally disabled homeless persons
Alameda County Medical Center Outpatient Psychiatric Services 14500 Foothill Blvd. San Leandro, CA 94578 510.895.4379 1411 E. 31st Street Oakland, CA 94602	Psychiatric services	Medicare Medical qualified

Agency	Services	Target Population
Alameda County Behavioral Health Care Services 15400 Foothill Blvd San Leandro, C 94578 510.582.2100	Detoxification, outpatient treatment, case management, medication support, for the mentally ill, referrals to counseling and mental health treatment	Alameda County Residents
La Clinica de la Raza 1515 Fruitvale Ave. Oakland, CA 94601 510.535.4000 Laclinica.org	Bi cultural mental health services	Latino community and PWH/A and Latino
Familias Unidas 205-39th Street Richmond Ca 94805 (510) 412-5930	Mental health coordination,	Contra Costa County residents
Lifelong Medical Care Berkeley, CA 510.20.4666	Primary medical care including HIV services and mental health services	Alameda and Contra Costa residents
Substance Abuse Treatment		
Alameda County Medical Center Substance Abuse Program 1411 E. 31st Street Oakland, CA 94602 510.437.5192	Relapse prevention, group treatment, and individual counseling mental health	Alameda County residents
9702 International Blvd Oakland, CA 94603 510.635.8422	Substance abuse and harm reduction counseling	PLWH/A 24 years of age or older
Catholic Charities of the East Bay HIV AIDS Services	Substance abuse counseling	PLWH/A in Alameda and Contra Costa counties
Emergency Financial Assistance		
Tri City Health Center HIV / Hepatitis Services 39184 State Street	Financial assistance	PLWH/A in southern Alameda County

Agency	Services	Target Population
Fremont, CA 94538		
AIDS Project of the East Bay 1320 Webster Street Oakland, CA 94612	Emergency funds for utilities, benefits advocacy	PLWH/A
Food Services		
AIDS Project of the East Bay 1320 Webster Street Oakland, CA 94612		PLWH/A
Alameda Emergency Food Bank 1900 Thau Way Alameda, CA 94501	Food	Low income Alameda County Residents
Project Open Hand 1921 San Pablo Ave. Oakland, CA 94610 1-800-551-6325 www.openhand.org	Nutritional support, daily meals, groceries including support for PLWH/A	Low income residents of Alameda County including PLWH/A
Vital life services 5873 San Pablo Ave Oakland, CA 94608 510.655.3435	Medical Case Management	PLWH/A
Food Bank of Contra Costa and Solano 925-676-7543	Food coordination services	Contra Costa and Solano County residents
Legal Services		
Alameda County Bar Association Lawyer Referral Service 70 Washington St. Oakland, CA 94607 www.acbanet.org	Legal services	Low income individuals
Bay Area Legal AID 405 14th Street Oakland, CA 94612 510.250.5270	Legal services	Low income residents and PLWH/A

Agency	Services	Target Population
Rubicon Programs Inc 2500 Bissell Ave Richmond, CA 94804 510 235 1516	Legal Services	Low income residents of Contra Costa County
East Bay Community Law Center 2921 Adeline Sreet Berkeley, CA 94703 510.548.4040	AIDS Legal services	PLWH/A and low income residents
Transportation		
Vital life services 5873 San Pablo Ave Oakland, CA 94608 510.655.3435	Transportation Assistance and other emergency assistance	PLWH/A
Neighborhood House of North Richmond 510-235-9780	Transportation and other emergency assistance	PLWH/A low income residents of Contra Costa County
Home Health Care		
Community Care Services		PLWHA and low income residents
Housing		
Alameda County Housing and Community Development 224 W. Winton Ave Hayward, CA 94544 510.670.5404	Support services and affordable housing to disabled, and PLWH/A	PLWH/A in imminent risk of homelessness
Affordable Housing Associates 1250 Addison Street Berkeley, CA 94702	Affordable housing in Alameda and Contra Costa Counties	PLWH/A, seniors, the homeless or at risk of homelessness
Catholic Charities of the East Bay HIV AIDS Services	Housing and rental assistance	PLWH/A in Alameda and Contra Costa counties

Profile of the Ryan White Program by Service Category

The report in the following table provides unduplicated client data by service category in Alameda and Contra Costa Counties for the Ryan White fiscal year 2007-2008.

Service Category	Unduplicated Clients Alameda County	Unduplicated Clients Contra Costa County	Providers
Ambulatory Care[7]	2,238	179	
			AIDS Healthcare Foundation
			AIDS Project of the East Bay
			Alameda County Medical Center
			Bay Area Consortium for Quality Health Care
			East Bay AIDS Center
			Lifelong Medical Care
			Tri City Health Center
Medical Case Management	2,268	498	
			Arc of Refuge
			Alameda County Medical Center
			Children's Hospital Oakland
			East Bay AIDS Center
			AIDS Project of the East Bay
			Lifelong Medical Care
			Tri City Health Center
			Nurse Case Management (Contra Costa Health Services)

[7] In Contra Costa County the bulk of Ryan White funding is used for case management services. Case managers coordinate county funded ambulatory care and other medical services for PLWH/A in Contra Costa County through the County's Basic Health Care program.

Service Category	Unduplicated Clients Alameda County	Unduplicated Clients Contra Costa County	Providers
Substance Abuse Treatment	195	47	Vital Life Services
			Ark of Refuge
			Catholic Charities
			East Bay Community Recovery Project
			Alameda County Medical Center
Oral Health	142	1	
			Alameda County Health Consortium
Mental Health	326	61	
			East Bay Community Recovery Project
			La Clinica de la Raza
			Pacific Center for Human Growth
			Tri Center Health Center
			Vital Life Services
			Children's Hospital
Home Health Care	22	2	
			Community Care Services
Emergency Financial Assistance food, utilities	943	105	Catholic Charities
Food	499	363	
			Ark of Refuge
			Project Open Hand
Emergency Housing	237	150	AIDS Project of the East Bay

Service Category	Unduplicated Clients Alameda County	Unduplicated Clients Contra Costa County	Providers
Assistance / Housing Advocacy			
			Tri Cities Health Center
			Vital Life
			East Oakland Community Project
Transportation	127	172	
			Vital Life Services
Client Advocacy Legal	214	4	
			East Bay Community Law Center
Unduplicated Clients	2,744	496	
Men	2,027	318	
Women	656	171	
Transgender	59	6	
Unknown	2	1	

Barriers to Care

The most persistent barriers to care in the Oakland TGA include:

- Inadequate public transportation: The Oakland TGA is a large geographic region with limited and inadequate public transportation upon which many of our clients rely.

- The high cost of housing combined with the chaotic lives that many mentally ill or substance abusing clients lead makes the stable housing necessary for sustained adherence to treatment difficult.

- Undiagnosed or untreated mental illness impedes some client's ability to access care, to adhere to medication regimens, and otherwise to manage their HIV disease.

- Substance use impedes adherence to medication regimens, and leads to missed medical appointments for many of the TGA's Care Act clients.

- Stigma makes some clients reluctant to seek either HIV prevention or care services.

- Limited English ability can create a barrier to accessing public services for some clients.

- Competing survival needs: Many of our clients contend with one or more chronic illnesses and struggle to satisfy basic survival needs (food and housing) in addition to dealing with their HIV disease.

Ambulatory care and support service providers in Alameda County reported the following barriers to their ability to serve clients:

- Lack of sufficient housing, mental illness and substance abuse services. "There's no place to send people".

- Recent reductions in county and state funding have led to reductions in clinical staff, which limits the ability of remaining staff to provide the intensive case management services required by acute need clients. Persistent low funding levels make it difficult to attract and retain the highest caliber professionals for a variety of job categories in the care continuum.

  Staff turnover has a negative impact on clients who must regularly adjust to new personnel. High turnover is especially detrimental to case management.

  Funding restrictions diminish the ability of agencies to conduct long term planning and can lead to disjointed service delivery as agencies scramble to accommodate funding limitations.

- Limited services that address the specific needs of the transgender community.

- Weak linkages between and collaboration among Community Based Organization service providers and in some instances competition among service providers.

- An absence of a system wide structure that supports and enforces ongoing collaboration, referral and communication among service providers

- Lack of support for agencies and community based organizations during periods of significant personnel or other organizational transitions.

- Weak --- some said “non existent” -- linkage between Alameda County Behavioral Health Care on the one hand and the County’s HIV care and prevention services on the other.

- A lack of transparency as it pertains to the funding, functioning and efficiency of the care continuum’s individual service providers.

- Insufficient treatment advocacy for clients which sometimes leads to weak compliance/adherence and discourages clients from remaining in care when they encounter clinicians, case managers and other service providers who they believe are insensitive.

- Weak coordination between care and prevention.

- Weak collaboration across the four Parts of Ryan White funding, especially as this pertains to quality management.

S E C T I O N 2

Where Do We Need To Go: What System of Care Do We Want?

Shared Vision

In assessing the continuum of care's current state and functioning, the Comprehensive Plan Steering Committee and the Planning Council identified several opportunities to reinvigorate the continuum's positive impact on the lives of PLWH/A by strengthening competency across the range of services

Contributors to this Plan agree that the ideal continuum of care should incorporate key principles of the Chronic Care Model of service delivery and should emphasize continuity, seamlessness; integration of services, collaboration among service providers, a team based approach to care involving clinicians and trained peers, and coordinated service delivery.

The Planning Council seeks the following outcomes from the system of care:

- A reduction in the number of people who are aware of their status and out of care.
- Improvement in the health outcomes for Ryan White Care Act clients including increases in the length of time between a positive test and AIDS diagnosis, and reduction in the severity and frequency of episodes of illness.

These outcome objectives stem from a shared vision that is compatible with the Health Resources and Services Administration's goal of zero disparities and 100% access, as well as with HRSA's *Four Factors with Significant Implications for HIV/AIDS Care*, services and treatment:

1. The HIV/AIDS epidemic is growing among traditionally underserved and hard-to-reach populations.
2. The quality of emerging HIV/AIDS therapies can make a difference in the lives of people living with HIV.
3. Changes in the economics of health care are affecting the HIV/AIDS care network.
4. Policy and funding increasingly are determined by outcomes.

Moreover, the ideal system of care will insure that Ryan White funds are used as funding of last resort and that use of all other local, state and federal resources will be maximized in order to provide high quality, continuous HIV care.

Given the role that substance abuse and mental illness play in the HIV epidemic in the Oakland TGA, an essential part of the ideal continuum will be a strengthened link between HIV primary care and the region's mental health and substance use treatment services.

Values for System Change and Guiding Principles

Statewide Coordinated Statement of Need

The California Statewide Coordinated Statement of Need (SCSN) is based on existing needs assessments, program descriptions, and consumer input from all of the California EMAs and TGAs, as well as input from a state-sponsored meeting to review a draft document and provide additional input.

Unmet Need

- Many PLWH/A in California still lack access to adequate HIV medical care. The Unmet Needs analyses for each Part A area have estimated that Unmet Need for medical care ranges from 20 to 60 percent of PLWH/A. For the state as a whole, an estimated 47 percent of PLWH/A are not in medical care, as determined by the HRSA Unmet Need Framework.

- Despite the availability of training opportunities for primary care physicians on emerging HIV issues and treatments, not all physicians or health care providers are able or willing to take advantage of these opportunities. The lack of adequately trained HIV care providers can result in a less than optimal quality of care that may impact the health of some patients.

- Medicare Part D implementation has resulted in increased costs for many of the dual eligible (those eligible for both Medicare and Medicaid) PLWH/A in California. There is also concern that the formularies of the Part D pharmaceutical providers may not include all of the medications needed by PLWH/A.

- The lack of oral health care services remains a significant gap in HIV services in California, and will deteriorate further as MediCal reimbursements decline. Needs assessments from several Part A grantees (including the Oakland TGA) identified dental care as a top unmet need for PLWH/A.

Emerging Trends

All of the following trends noted in the SCSN have been observed in the Oakland TGA:

Co-morbidities: Liver diseases, including hepatitis C in particular, are increasingly common among intravenous drug users (IDUs) and interfere with treatment for HIV, limiting the medications that can be used, and depriving people of treatment options. IDUs and other substance users face high HIV risks, difficulties getting into care, and a higher incidence of co-morbidities such as mental health problems and hepatitis C infection, as well as other health problems related to substance use.

Disproportionate Impact on African Americans: African Americans are disproportionately affected by HIV in California, carrying a burden of HIV disease many times larger than their presence in the population. In some parts of the state, African Americans are less likely to be on

antiretroviral therapy, more likely to be out of care, and have lower survival rates. The system of care for PLWH/A in California is working to identify and address disparities for people of color, including African Americans.

Immigration; Immigrants, especially those who are undocumented, experience significant barriers to accessing care due to limited system capacity to provide culturally and linguistically appropriate services. Recent immigrants from Mexico, as well as elsewhere in Central and South America, are likely to be monolingual Spanish speakers, and many are not literate in any language. Mexican nationals and Mexican Americans are the largest segment of Latinos, a mix of ethnic groups and cultures which compose the largest racial/ethnic group in the state. Among Mexican immigrants, an increasing number are indigenous peoples, many of whom are not fluent in either English or Spanish. Latinos with HIV are less likely to have health insurance, and are therefore more heavily reliant on CARE Act funding services than other groups.

Reentry from Prison and Jail: California has the third largest correctional system in the world. Thousands of PLWH/A are incarcerated at any one time, a large proportion of whom need substance use treatment and housing assistance upon release. Both substance use and homelessness are major barriers to care for this and other populations in the Oakland TGA. As larger numbers of PLWH/A are being returned to the community due to jail and prison overcrowding, or transferred among different correctional settings, it is essential that transitional services and support for parolees be provided, including ensuring that prisoners are released or transferred with a supply of prescribed medications, and with appropriate linkages to services.

Aging Population of PLWH/A: In large part because California was one of the earliest epicenters of the epidemic, it is now home to increasing numbers of long-term survivors who are growing older and having to address health challenges related to aging as well as HIV disease. This group will likely increase over time, as PLWH/A grow older.

MSM: The category of men who have sex with men (MSM) includes men who identify as gay or bisexual, and those who do not identify as such. MSM continue to be the majority of PLWH/A in California, as they have been since the very beginning of the epidemic. They have the highest prevalence rates of any group in California, and are living with HIV at rates disproportionate to their presence in the population.

IDUs: Intravenous drug and other substance users face high HIV risks, difficulties getting into care, and a higher incidence of co-morbidities such as mental health problems, hepatitis C infection, and other health problems related to substance use.

Methamphetamine Users: Methamphetamine and amphetamine use is a long-standing problem in California, especially for gay/bisexual men.

Cross Cutting Issues and Challenges

High Poverty Rates: Poverty has a significant impact on many PLWH/A. It is one of the most basic barriers to care, quality of life, and good health outcomes. People living in poverty must not only face the burden of having insufficient resources for basic necessities, but they are often the individuals who are least likely to be familiar with the health care system, have the most

distrust of traditional health care services, and are most in need of support in order to access basic medical care.

Stigma: Gay and MSM of color often face more stigma related to both their sexual behavior and HIV. They are less likely to access care, and the Los Angeles Needs Assessment found that the most common barriers to care for MSM of color were a lack of knowledge, provider insensitivity, and discrimination.

Cultural Competency: In a region as culturally diverse as California, it is vital that providers offer services that respond to the specific cultural needs and backgrounds of their service populations. A lack of service providers who reflect or understand the ethnic, cultural, or lifestyle background of the individuals they serve can result in miscommunication, misunderstanding, or a lack of trust between provider and patient.

Language Barriers: Language and cultural barriers create significant problems for PLWH/A whose primary language is not English, particularly in terms of the lack of professional and paraprofessional providers who are bilingual in either English and Spanish or in English and one or more Asian/Pacific Islander languages.

Data Management: Many believe problems with data reporting and a lack of effective evaluation of care services and client outcomes are serious issues for care providers. HIV service providers have been required to collect and report data into multiple reporting systems because each of their programs has different reporting requirements and a different reporting system. Duplicative reporting requires significant staff time and is especially difficult in times of shrinking budgets and increasing demand for services. It is anticipated that Alameda County's adoption of CAREWare will alleviate some of these problems.

Integration of Services: The quality, scope, and coordination of care for PLWH/A in California is affected by the ability of providers to plan and develop collaborative, multidisciplinary approaches to HIV service and care, especially in light of the changing, complex needs of those affected by the epidemic.

Staff Turnover: As reported by service providers in Alameda County, many HIV service organizations have problems in retaining staff members over long periods of time and in rapidly filling key positions. Staff turnover disrupts trusting relationships developed over time between clients and staff members and creates ongoing training needs.

Transportation: Lack of consistent access to transportation remains a barrier to accessing HIV services for some people. This problem exists in both rural and urban settings.

Cost: The costs of providing services continue to increase, including salaries, rents, insurance, and business overhead. California has some of the highest health care costs in the country, as measured by the Medicare Cost Index.

Critical Gaps

- There is a lack of affordable, safe housing units for all low-income groups in California including PLWH/A in the Oakland TGA. Although housing price increases have abated, the housing crisis in California continues to have a disproportionate impact on low income or no income people. Providing health care and other services to the homeless and marginally housed is more complex and more costly. Stabilizing the homeless is essential to providing them with optimal care.

- There are too few PLWH/A working in both paid and volunteer positions in the care system in California who can provide direct assistance, support, and advocacy to others living with HIV.

- Child care is a gap for women and families with children. Without respite child care, it can be difficult to keep medical appointments.

- Up to 27%of PLWH/A in California still do not know their HIV status, according to CDC estimates.

- In some California regions, reduced HIV funding has led to the reduction or elimination of home-based services for PLWH/A, including home health, attendant, and nursing care; hospice care; and respite care for family members and other caregivers.

- There is a shortage of long-term counseling and therapeutic services and psychiatric care for PLWH/A.

- There is a lack of programs for the multiply diagnosed in California.

- Not all medical providers are aware of, or can advocate for, their clients' involvement in clinical trials, and thus for many PLWH/A who live in rural areas, clinical trials may not be available.

- Stigma related to sexual behavior and HIV continues to inhibit MSM – especially MSM of color – from accessing care. Provider insensitivity is still a barrier in accessing care.

The SCSN states that despite the progress that California has made in providing access to medical care and new drug therapies for HIV, the size and diversity of the state of California present unique and daunting challenges to planners of HIV care and services. Poverty and lack of health insurance complicate efforts to deliver effective, comprehensive services to persons with HIV. Much work remains to be done in the following four areas: ensuring access to quality HIV/AIDS care, developing new approaches to integrating services, maximizing resources, and bringing people with HIV who are aware and unaware of their serostatus into care.

The key overriding need among California's HIV/AIDS service providers is to make certain that CARE Act services are available, accessible, and culturally and linguistically competent across all service categories, and that we come as close as possible to HRSA's goal of access to quality HIV care for all. This is both increasingly important and increasingly challenging as the

population of CARE Act-supported PLWH/A in California are increasingly poor, homeless or marginally housed, and diagnosed with co-occurring conditions.

Expanded data collection with the introduction of CAREware in Alameda County will support agencies in advancing the plan's objectives by more quickly and accurately identifying service gaps and deficiencies; producing meaningful data that allow for effective assessment of the quality, impact, and outcomes of services; and planning resource allocation scientifically.

Values and Principles

A Comprehensive Plan Steering Committee was convened and held several meetings to determine the scope of this Plan, the values and principles that were to inform the structure and functioning of the "ideal continuum" and the Plan's goals and objectives. The committee's members included managers from Alameda and Contra Costa County Health Departments, service providers including representatives of the region's Part C and Part D grantees, PLWH/A, the chair and vice chair of the Planning Council and other members of the Planning Council and community members.

The committee sought to select values and principles that when operationalized would lead to increased access to primary care and essential support services, increased retention in care, especially for hard to reach and emerging populations such as transgender individuals, monolingual Latinos, MSM of color, women, IDUs, and other PLWH/A who, due to stigma and other barriers, are reluctant to seek care or have difficulty remaining in care.

The values and principles were also chosen to support the need identified by public health department staff, community based service providers and consumers for a model of care delivery and continuum of care operation that emphasized collaboration and coordination among service providers.

The proposed values and principles were presented to the full Planning Council and adopted by consensus.

The values are:

- Respect, Compassion, Trust and Empathy
- Access to Services and an End to Disparities
- Accountability and Professionalism
- Seamlessness, Integration, Continuity and Coordination within the Continuum of Care
- Flexibility and Adaptability

Respect, Compassion, Trust and Empathy: These values are essential to outreach, recruitment and retention of PLWH/A in this TGA. Our clients have frequently been marginalized and are typically low income individuals with a number of poor health outcomes and distrust of providers.

These values pertain to relationships between all involved in the continuum of care. They are important to the operation of the continuum in that they are hallmarks by which service

providers, Public Health Department staff in both counties, and clients themselves should interact with each other.

Access to Services and an End to Disparities: Again, these values pertain to the full range of relationships among and between consumers, providers and health jurisdiction staff and management. Given the disproportionate impact of HIV/AIDS on minority communities in the Oakland TGA, combined with other persistent community health and social inequities, the Steering Committee and Planning Council seek to establish a continuum that will reduce disparity in HIV care and disease progression.

Accountability and Professionalism: These values apply to the work of service providers, case managers, staff and consumers. Exploration of expanded use of the case management hub model, intense case management for acutely affected individuals, ongoing training of case managers and the possibility of centralized training and cross training in HIV prevention and care for case managers, proposals for expanded use of case conferencing, and the expectation of an "informed and activated patient" as called for by the Chronic Care Model of service delivery, all reflect the TGA's commitment to increased levels of professionalism and accountability.

Seamlessness, Integration, Continuity and Coordination within the Continuum of Care: As funds of last resort that are primarily used to purchase core services for PLWH/A, one function of Ryan White Part A is to provide emergency care until PLWH/A can be linked to other funding sources. Coordination with other programs and funding sources is essential. Ideal care is continuous regardless of a person's ability to pay. Seamless care is achieved by coordination among funding sources. An improved continuum of care would reduce fragmentation in the care system and promote integration of prevention and care and consistency of services.

Integration includes:

- Interdisciplinary, team based and collaborative service delivery.
- Co-location of case management, medical and behavioral health care services (e.g., a medical home).
- A system wide training plan for case managers.
- Standards of care and scopes of work for service providers that support collaboration, client centered care delivery.

An integrated system will focus on removing the fragmentation of the three major systems of care: medical, mental health and substance abuse treatment. Case management services will link health care services, reduce fragmentation, duplication and unnecessary utilization of services and promote individual responsibility for healthy lifestyles.

Flexibility and Adaptability: These values are increasingly important in the face of shifting budget priorities at the federal, state and local levels, limited funding, and changing legislative state and federal Care Act legislative mandates.

Flexibility allows the system to target the appropriate level of care to individuals based on an individual's level of disease acuity, ability to function independently, progression of illness and/or the presence of co-morbid conditions.

Stratification will allow those with a temporary acute need to obtain short term intensive case management, those with chronic high levels of need to obtain longer term case management services, and high functioning and relatively healthy individuals simply to be referred to services.

Seamlessness and Coordination form the operational framework for a continuum that is intended to support care plan compliance and drug adherence and retain in care a population that faces numerous medical and mental health challenges. Monitoring will focus on system coordination and enhanced, standardized training for medical case managers. The ideal system will integrate HIV prevention with the full range of care and treatment services.

Coordination also pertains to the system's ability to help people with substance use and mental health diagnoses maintain the best health possible and remain engaged in their HIV care. For substance using individuals, these activities will continue to include outreach, harm reduction such as needle exchange, HIV testing in locations convenient to substance users, drug and alcohol detox and drug and alcohol residential treatment and recovery support. For individuals with mental health difficulties, linkage to psychiatric inpatient units, day treatment facilities, psychiatric residential treatment and psychiatric outpatient clinics will continue to be necessary.

The clear implication of an epidemic that increasingly effects dually diagnosed substance abusing individuals is that HIV treatment services and behavioral health services must be better coordinated.

The ideal system of care will involve a case management function that is able to identify and effectively link clients to all available medical, behavioral health and support services, and will be integrated with a primary care function that is team based and include roles for peer and near peer staff.

Guiding Principles

The Continuum as well as individual services will adhere to principles that will shape this integrated system of chronic care delivery as follows:

- Maintain a commitment to ending health disparities.
- Proved client centered and coordinated services.
- Integrate Prevention and Care.
- Maintain and require collaborative partnerships among service providers.
- Encourage early and meaningful involvement on the part of PLWH/A in the design, development and evaluation of service delivery.
- Offer continuous training, capacity building and leadership development.
- Provide culturally and linguistically appropriate services.

S E C T I O N 3

How We Will Get There: Goals, Objectives and Action Plan

The Comprehensive Plan Steering Committee settled on four goals with related objectives and tasks intended to reduce the number of people out of care and improve health outcomes for PLWH/A.

The goals are to:

(1 Provide access to and retain in high quality HIV medical care those who are aware of their status but not in care.
(2) Optimize the continuum of care's impact.
(3 Enroll out of care clients in care.
(4) Insure that all funded services are of the highest quality throughout the TGA.

The steering committee also determined that strengthening integration and coordination of core and support services was the most important system improvement needed in the Alameda County continuum of care and was necessary to accomplish these goals. The steering committee examined and considered a number of care delivery models including the case management hub, the one stop shop and others as ways of achieving this system improvement and of making Alameda County's continuum of HIV care more client-centered, efficient and cost effective.

It was agreed that the best approach to strengthening the integration and coordination of the system and achieving the four goals would be to test and assess the viability of a number of approaches that emphasize team-based primary care, coordination of services, and then to select the most appropriate model or combination of models for expanded use throughout the TGA. Moreover the Steering Committee suggested exploring the possible expansion of the case management hub model currently in use in Contra Costa County to Alameda County.

It was acknowledged that to the extent possible the central point of access to the care continuum should be determined by the client's most critical service need, the level of disease acuity and the client's ability to function, but that in most instances medical case management and primary care would form the core of care delivery.

Goals, Objectives and Activities

Goal 1: Implement and evaluate service delivery models to provide access to and retain in high quality HIV medical care those who are aware of their status but not in care and to increase retention of PLWH/A in care					
Activity		**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
Objective 1.1 Plan for adoption of a Case Management Hub Model throughout the TGA based on the Chronic Care Model of Service Delivery					
1.1.a	Create Case management hub task force to include case managers and County Medical Services Program (CMSP) representatives from both counties.	March 2009	Grantee	Grantee	
1.1. b	Convene the Task Force, establish priorities, assign responsibilities.	March 2009	Grantee Program Managers	Grantee Program Managers	
1.1.c	Implement bimonthly meeting of Ryan White Funded case managers to design linkage protocols, design and evaluation tools.	March 2009	Grantee Program Managers	Grantee Program Managers	
1.1.d.	Adopt and monitor a contractual requirement of providers to implement a "warm hand off" (direct and verified referral) for newly positive clients.	June 2009	Grantee Program Managers	Grantee Program Managers	
Objective 1.2.Develop and locally evaluate a *brief case management* pilot program integrated with prevention and testing targeting newly diagnosed people and those who are tenuously engaged in care.					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
1.2.a	Convene advisory committee with representatives from Bridge Program and other	June 2009	Grantee and designated staff from Contra Costa AIDS	Grantee and designated staff from Contra Costa AIDS	

	similar programs from both Alameda and Contra Costa Counties.		Program	Program	
1.2.b	Select pilot program site(s) [at least one in each county].	June 2009	Grantee and designated staff from Contra Costa AIDS Program	Grantee and designated staff from Contra Costa AIDS Program	
1.2.c	Develop linkage protocols and design and evaluation tools.	August 2009	Grantee and designated staff from Contra Costa AIDS Program	Grantee and designated staff from Contra Costa AIDS Program	
1.2.d	Develop and pilot a project with designated case managers providing varying levels of service intensity based on stratification of patients by level of disease acuity, co-morbidities and ability to function.	October 2009	Grantee and designated staff from Contra Costa AIDS Program	Grantee	
1.2.e	Review evaluation results and determine feasibility of continuing the model.	March 2010	Independent evaluator to be designated	Independent evaluator to be designated	
Objective 1.3 Pilot and evaluate a local adaptation of a team based integrated care program.					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
1.3.a	Specify services to be included.	March 2010	Grantee staff and program advisors to be designated	Grantee	
1.3.b	Specify disciplines to be integrated.				
1.3.c	Specify requirements for case conferencing, integrated treatment plans and centralized supervision and training of outreach workers/ peers and clinicians; Develop and conduct	May 2010	Grantee staff and program advisors to be designated	Grantee	

	training and implement pilot project at one or more sites (at least one each in Alameda and Contra Costa counties.				
1.3.d	Review evaluation results and determine feasibility of continuing the model.	November 2010	Independent evaluator	Independent evaluator	
Objective 1.4 Develop a comprehensive training & capacity development program for service agencies and PLWH/A to include client advocacy training, peer learning opportunities and health literacy					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
1.4.a	Determine training goals and objectives.	March 2009	Grantee and representative from Contra Costa	Grantee	
1.4.b	Develop RFP or designate Alameda and Contra Costa County staff as trainers.	May 2009	Contractor / Consultant or TGA staff depending on funding	Grantee	
1.4.c	Design and approve curriculum.	June /July 2009	Contractor / Consultant or TGA staff depending on funding	Grantee	
1.4.d	Offer first training session and evaluate.	September - December 2009	Contractor / Consultant or TGA staff depending on funding	Grantee	

Goal Two: <u>Optimize the continuum of care's impact</u> by (a) identifying and using all other available resources including Alcohol and Other Drug (AOD) and mental health services, (b) by structuring and requiring coordination of services among service providers, (c) by eliminating unnecessary duplication of services and competition, (d) by organizing and requiring the sharing of resources, and (e) by strengthening data collection and technology processes and procedures.					
Activity		**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
Objective 2.1 Develop and require training of all providers in the use of a consistent formal new client orientation to the care continuum.					
2.1.a	Develop a client orientation curriculum.	February 2009 – June 2009	Grantee and Contra Costa AIDS Program staff and designated service agency reps	Grantee	
2.1.b	Implement client orientation training for agency staffs.	June 2009 and quarterly thereafter	TGA service provider reps with guidance and monitoring from grantee	Grantee	
Objective 2.2 Develop a standardized resource manual and pocket guide to be distributed at intake to all clients regardless of point of intake					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
2.2.a	Develop and distribute a client orientation manual.	By December 2009	TGA service providers with designated grantee and Contra Costa County AIDS program staff	Grantee	
Objective 2.3 Develop a series of quarterly agency/provider meetings for all funded providers by discipline (case manager, agency director, client services etc.) to monitor the continuum of care and make adjustments					
Objective 2.4 Develop a pilot project using text messaging, instant messaging and other technology for youth client recruitment and retention in care.					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
2.4.a	Develop and disseminate an RFP for development of a pilot	By January 2010	Grantee	Grantee	

	project.				
2.4.b	Implement and evaluate pilot project in Contra Costa and Alameda sites.	June 2010	Contractor /Consultant or Grantee staff to be determined		
Objective 2.5 Develop an institutional relationship between Alameda Behavioral Health Care (BHCS) and Alameda County Public Health Dept Office of AIDS Administration (Develop systematic coordination including interagency protocols) for care and prevention services for clients of Alameda County Behavioral Health Care in order to strengthen linkages for care and treatment of PLWHA with substance abuse disorders, to improve service coordination and treatment planning and to integrate treatment for co—occurring mental illness and substance abuse with HIV medical care.					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
2.5.a	Reestablish the BHCS/OAA Collaborative Working Group monthly meetings.	March 2009	Directors Alameda County Public Health Department and BHCS Director	Directors Alameda County Public Health Department and BHCS Director	
2.5.b	Initiate an ongoing OAA collaboration with BHCS and jointly funded service providers to identify and work on common problems.	March 2009 and ongoing	Grantee	Grantee	
2.5.c	Establish standard protocols for referrals.	June 2009	Designated staff from Grantee and BHCS	Grantee	
2.5.d	Establish a collaboration with BHCS on the OAA's Santa Rita Jail Initiative.	June 2009	Kabir Hypolite, Director OAA and designated BHC staff	Grantee	
2.5.e	In collaboration with relevant BHCS staff, establish mechanism for BHCS referral of clients to HIV care.	November 2009	Designated Ryan White funded agency staff and BHCS staff	Grantee and BHCS Staff	
2.5.f	Design and implement HIV sensitivity and cultural competency training for relevant non-HIV staff, such as front desk and financial staff, at	December 2009 and quarterly	Grantee and designated Ryan White funded agency staff	Grantee	

	service agencies.				
2.5.g	Identify funding and conduct HIV testing in detox in Alameda County.	January 2010	To be determined	Grantee	
2.5.h	Convene Alameda County Mental Health and Substance Abuse providers to plan a collaborative application for the next SAMHSA HIV Set-Aside RFP which is scheduled for Spring 2009.	March 2009	Grantee	Grantee	
Objective 2.6 Increase care provider and case manager awareness of available risk reduction services and how to refer clients for services such as prevention with positives, harm reduction, and partner counseling.					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
2.6.a	Develop and implement training.		Designated Grantee Program Manager	Grantee	
Objective 2.7 Develop and implement a Coordinated Case Management Pilot Project at two sites (one per county).					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
2.6.a	Identify Project Site and clientele.	June 2010	Designated Grantee Program Manager	Designated Grantee Program Manager	
2.6.b	Project Development: Establish case management team to include case manager, peer advocate, and service providers; Assign roles, develop criteria for assigning clients to levels of care and clear roles and practices for different levels of care; Develop a system wide training program for case managers at all levels.	No later than January 2011	Grantee (Director of Care and Prevention)	Grantee	
Goal Three: Enroll out of care clients in care.					

	Activity	Time Frame	Responsibility Party	Progress Reporting	Status
Objective 3.1 Create and monitor use of a standard risk assessment tool for new clients that links prevention and care.					
		No later than January 2010	Grantee Director of Care and Prevention	Grantee	
Objective 3.2 Develop and implement training for case managers and other appropriate agency staff on new client orientation procedures.					
Objective 3.3 Expand case finding through the use of social network interventions, including adapting demonstrated models, such as Popular Opinion Leader to reach out of care clients and recruit them into care.					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
3.3.a	Identify target population.	January 2010	Grantee Director of Care and Prevention	Grantee	
3.3.b.	Review and select case finding, service promotion and social marketing strategies and models, including innovative ones that are appropriate for the Oakland TGA and its targeted population groups, including strategies that make use of emerging technologies and media, such as text messaging.	June 2010	Grantee, Contra Costa and selected service providers	Grantee	
3.3.c.	Identify and apply for funding.	June 2010	Grantee and Contra Costa AIDS Program Management	Grantee	
Objective 3.4 Expand the use of client intake procedures used by Part D providers (Alameda County Family Care Network) to designated agencies in both counties (standard assessments include: psych social, housing, ADAP, MediCal enrollment, support group enrollment, and introduction to medical providers).					

	Activity	Time Frame	Responsibility Party	Progress Reporting	Status
3.4.a	Assess retention rates and select and collect data on other outcome measures, and determine advisability of further expansion of use of this standard assessment package.	March 2009 through March 2010	Grantee QM staff and other Grantee designated Program Managers	Grantee	
Objective 3.5 Expand enrollment of HIV positive reentry population in primary care focusing on Santa Rita Jail.					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
3.5.a	Provide training for medical clinic staff at Santa Rita Jail Clinically-based HIV Testing, Risk Assessment and Cultural competency.	June 2009	Grantee Program Manager to be designated	Grantee	
3.5.b	Develop an HIV Testing \ Screening program model based on best practices in other Bay Area counties.	January 2010	Grantee Program Manager to be designated	Grantee	
3.5.c	Explore possibility of Santa Rita jail becoming a state testing site so they can use the rapid test and bill the state and routinely offer test to all inmates upon intake, at each clinic visit and upon discharge.	Present through January 2010	Grantee Program Manager to be designated	Grantee	
3.5.d	Develop a “Health Education Packet” for distribution upon release that includes the new client orientation materials	January 2010	Grantee Program Manager with input from designated case managers	Grantee	

	HIV Pocket Guide, HIV Education and Prevention information, condoms and lube, testing and primary care information, needle exchanges sites, etc.				
3.5.e	For a limited number of reentering parolees, establish a formal transitional case management program in conjunction with the creation of a position or designation of appropriate OAA staff as health care advocate to transition inmates to care and support services including housing; to collaborate with jail staff in discharge planning.	January 2010	Grantee Program Manager with assistance from designated case managers	Grantee	
3.5.f	Designate "Healthy Oakland" in Alameda County and locate a similar clinic in Contra Costa County as a "medical home" or reentry clinic to which released inmates can be discharged and their medical records forwarded; services would include medical case management, psycho social case management and referrals to necessary support services	January 2010	Grantee and Contra Costa Program Managers	Grantee	

Goal Four: ***Insure all funded services are of the highest quality***					
Objective 4.1 Review and update the "care management" standards of care					
	Activity	**Time Frame**	**Responsibility**	**Progress**	**Status**
4.1.a	Reconvene Continuous Quality Improvement Committee.	March 2009 and quarterly thereafter	Quality Management staff from Contra Costa and Alameda	Grantee	
4.1.b	Conduct quarterly trainings (learning sessions) focused on improving care for people infected with HIV using the Chronic Care Model and Plan Do Study Act (PDSA) Cycle.	Quarterly beginning June 2010	Quality Management staff from Contra Costa and Alameda	Grantee	
4.1.c	Develop and implement a provider cultural competency self-assessment tool.	June 2009 and as needed thereafter	Quality Management Staff both counties	Grantee QM Staff	
4.1.d	Develop TGA-wide standards related to mental health and substance abuse	June 2009	Quality Management Staff both counties	Grantee QM Staff	
4.1.e	Continue monitoring of common standards for all other core services.	Present and continuously	Quality Management Staff	Grantee QM Staff	
4.1.f	Revise as necessary and monitor implementation of a common set of best practices and procedures to guide the provision of all Part A funded services throughout the Oakland TGA	Ongoing	Quality Management Staff both counties	Grantee QM Staff	
Objective 4.2 Use aggregate data to evaluate performance					

	Activity	Time Frame	Responsibility Party	Progress Reporting	Status
4.2.a	Develop plan to track retention in care of all pilot projects within this Plan	Ongoing	Grantee QM Staff	Grantee QM Staff	
4.2.b	Continue to use information from monitoring to develop new, refined outcome measures incorporating baseline data from 2008.	March 2009 and ongoing	Quality Management Staff both counties	Grantee QM Staff	
4.2.c	Administer client satisfaction surveys in both Alameda and Contra Costa Counties.	November 2009 and November 2011	Quality Management Staff both counties	Grantee QM Staff	
Objective 4.3 Provide on-site QI consultations and coaching					
4.3.a	Provide QM technical assistance and trainings.	As needed	Quality Management Staff both counties	Grantee QM Staff	
4.3.b	In collaboration with the AIDS Education and Training Center, develop and present a new training program designed to orient and educate Planning Council members and consumers to the EMA's emerging quality assurance and chronic care models	To be determined	Grantee QM staff	Grantee QM Staff	
Objective 4.4 Facilitate QI project development using multidisciplinary teams					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**

4.4.a	Continue to identify and implement quality improvement projects (PDSA's) based on outcome evaluation.	Ongoing	Grantee QM staff		
Objective 4.5 integrate QI into ongoing planning and work					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
		Ongoing	Grantee QM staff		
4.5.a	Conduct an annual evaluation of the quality management plan involving the Grantee, Contra Costa County AIDS Program, Planning Council members, contractors, and providers, and prepare and circulate an annual quality management plan update.	February 2009, 2010 and 2011	Consultant or QM staff depending on funding and availability	Grantee QM Staff	
Objective 4.6 Provide reports to relevant individuals and groups					
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
4.6.a	Continue to assess and revise program monitoring tools, review standardized reporting mechanisms for program monitoring, and provide outcome data to the Planning Council to assist in priority setting and allocation.	April 2009, 2010, 2011	Grantee QM Staff	Grantee	
4.6.b	Continue to develop, review, and disseminate service				

	standards related to Part A funded service categories and programs.				
4.6.c	Update the Planning Council on Quality Assurance (QA) activities on a monthly basis.	Monthly	Grantee QM Staff	Grantee	
	Activity	**Time Frame**	**Responsibility Party**	**Progress Reporting**	**Status**
Objective 4.7 Establish pilot project to collect unit cost data from a primary care providers in order to assess cost of serving special and emerging populations.					
4.7.a	Select pilot site or agency and provide technical assistance as needed. Implement project and evaluate data.	March 2009 through October 2009	Grantee QM and budget staff	Grantee QM and budget staff	
4.7.b	Expand unit cost reporting requirement to other service providers.	Incrementally beginning October 20009	Selected service providers with technical assistance from Grantee QM and budget staff	Selected service providers with technical assistance from Grantee QM and budget staff	

S E C T I O N 4

How Will We Monitor Our Progress in Meeting Short and Long Term Goals?

Section 3 described the goals, objectives and activities that the TGA will undertake in the 2009-2011 period. The Planning Council and the Office of AIDS Administration (OAA) will monitor the progress towards achieving these goals throughout the three year period covered by this Plan.

Using Data For Evaluation

The Unmet Need Framework will continue to be the primary measure of whether and by how much the number of out of care PLWH/A decreases over time. Because the framework includes people who were diagnosed elsewhere but moved to the Oakland TGA, but does not include people diagnosed here who move elsewhere and receive care in other jurisdictions, the framework is only a partial reflection of unmet need for medical care. In addition to the framework, the following methods will be used:

- Client satisfaction surveys will be administered at least twice during the 2009-2011 period to determine whether changes to the care continuum have been successful from the consumer point of view. Client satisfaction surveys were completed in 2006 for primary care, mental health, case management and substance abuse services and the results were reported to the Planning Council at the annual retreat in April 2006. TGA QM staff will conduct client satisfaction surveys again at least twice in the 2009-2011 period.

- Chart reviews will be used to measures clinical outcomes and system performance. Chart reviews will collect data on indicators used to measure accessibility, continuity, effectiveness, efficacy, efficiency, and client satisfaction. The chart reviews will measure such things as adherence to treatment plans, and treatment standards, improvements in mental health, oral health, HIV disease acuity and disparities in disease acuity and mortality.

- A revised region wide Needs Assessment will be conducted at least once before the end of the three year period to determine the range, availability and access to core and support services, and to determine gaps in services.

- Mandatory fiscal and programmatic monitoring is an ongoing function carried out by Alameda County's Office of AIDS Administration and Contra Costa County's AIDS Program.

Improving Client Level Data

The introduction of CAREWare in Alameda County will strengthen the ability to measure and compare outcomes and assess disparities across a range of variables including, race/ethnicity, gender and other demographic characteristics. CAREWare will be fully implemented by February 2009.

Measuring Clinical Outcomes

The Quality Data Committee of the Planning Council will oversee efforts to measure clinical outcomes. This will be an integral part of the TGA's Quality Management program, which will involve the coordinated efforts of QM staff, a Continuous Quality Improvement Committee, service providers and the Planning Council.

TGA quality management staff will have primary responsibility for data collection, outcome measuring and program evaluation for all Parts of HRSA's Ryan White Care Act activities in the Oakland TGA.

The TGA's QM staff will implement a region-wide quality management program and quality management plan that will provide outcome based approaches to ensuring the quality of HIV care. This plan will include the use of outcome measures for all HRSA core services and will incorporate these outcome measures into TGA-wide standards of core service provision.

The Quality Coordinator from Alameda County briefed the Council on Quality Improvement Principles using the Chronic Care Model, and on data and outcome reporting in 2006 and 2007, and provided a training for the Planning Council on information from the National Quality Center's Train the Trainer (TOT) program. It is anticipated that the QM Coordinator will continue these types of activities.

The Care Act requires the Planning Council to review and utilize service outcome and quality assurance data in the prioritization and allocation of Part A funding. To help the Council fulfill this mandate, the QM Coordinator will train the Planning Council on the Chronic Care Model and on Quality Assurance activities, and will continually review with the Council the Quality Management Plan, Standards of Care, and service indicators.

The Planning Council will be updated on Quality Assurance (QA) activities on a monthly basis throughout the three-year Plan period. In addition, consumers will be offered QA training offered by the AIDS Education and Training Centers (AETC) and the Alameda County Office of AIDS Administration (OAA) in order to increase their understanding of Continuous Quality Improvement (CQI). Consumers will also be involved in implementing CQI activities with specific emphasis on Standards of Care and service outcome indicators. Consumers who are qualified may participate in site visits to grantees and may also help evaluate quality management activities in the Oakland TGA.

The Quality Data Committee will provide ongoing input and direction on the Oakland TGA Quality Management Program and its relationship to the Comprehensive Plan. This committee will meet quarterly or as needed to fulfill the following three responsibilities: to annually review and update the Quality Management Plan, to establish quality assurance processes, and to conduct a variety of evaluation activities. The Committee will determine program priorities and identify performance measures to assess and improve performance, make recommendations for appropriate education relating to quality improvement concepts and techniques, and make recommendations to the Planning Council as a whole regarding implementation of quality-related Plan objectives and action steps. The committee will report cumulative service outcome results to the Planning Council, Executive Committee and Service Committee.

Measuring and Reporting on Outcomes

Using information from the January 2007 data training and from outcome and client satisfaction reports, outcome measures have been established for the TGA. The TGA will use core outcome measures and reports on outcomes for primary care, case management, substance abuse, home health care and mental health. The Office of AIDS Administration Quality management staff will report the results of these outcome measures at regular intervals to the Planning Council, including one or more reports during the annual priority setting and allocation process.

QM staff will monitor service provider progress toward specified outcome measures through data reports and technical assistance, and through partnering with agencies to help them track and achieve required program outcomes.

Ongoing and tailored technical assistance will be provided to contractors on how to collect/document outcomes and how to use the results for improvement projects. OAA staff will conduct an annual review of outcomes and negotiate with contractors for the upcoming fiscal year.

Outcome measures will include:

- *Access to Care*. Percentage of clients enrolled that have a minimum of two primary care visits within the fiscal year.

- *Case Management.* Increase in the percentage of clients who receive risk reduction education or referral to either PCRS or Prevention with Positives interventions.

- *Home Care Services.* Percentage of clients assessed every 60 days for need in the following home health areas: durable medical equipment; therapies (e.g., physical, speech or occupational); registered dietician; home health aide; medical social worker.

- *Mental Health.* Percentage of HIV positive clients whose treatment plans address issues (e.g., kept appointments, and medication adherence) identified in the comprehensive assessment.

- *Oral Health.* Percentage of clients that receive an intraoral exam at least annually that includes dental caries examination and soft tissue examination. Increase in the number and percent of seropositive clients (without dental coverage) seeking oral health care services. Improvement in oral health. Decrease in advancement to more serious dental disease. Increase in number of kept appointments